Prevention and Response to Gender-Based Violence (GBV) in Lagos State

Standard Operating Procedure



Spotlight Initiative

LAGOS STATE DOMESTIC AND SEXUAL VIOLENCE RESPONSE TEAM (DSVRT)

CEWHIN

Table of Content

Acknowledgement

Acronyms

CHAPTER 1: INTRODUCTION 06

CHAPTER 2: DEFINITIONS AND TERMS 08

CHAPTER 3: GUIDING PRINCIPLES 13

CHAPTER 4: IDENTIFICATION OF VICTIMS AND DISCLOSURE 17

CHAPTER 5: REPORTING AND REFERRAL 20

CHAPTER 6: ROLES AND RESPONSIBILITIES FOR SURVIVOR ASSISTANCE 25

CHAPTER 7: CASE MANAGEMENT 34

CHAPTER 8: RESPONSIILITY FOR PREVENTION 39

CHAPTER 9: COORDINATION AMONGST ACTORS AND AGENCIES 41

CHAPTER 10: RESPONSIBILITIES OF CASEWORKERS AND AGENCIES FOR STAFF CARE 42

CHAPTER 11: INFORMING DISSEMINATION TO STAKEHOLDERS ABOUT THE GBV SOPS 43

CHAPTER 12: MONITORING AND EVALUATION OF SERVICE QUALITY 44

CHAPTER 13: DOCUMENTATION, INFORMATION MANAGEMENT AND DATA MONITORING 46

Appendices

Bibliography

Appendix I	Consent Form
Appendix II	Intake and Referral Form
Appendix III	Dignity Kit Checklist
Appendix IV	Incident Report Form
Appendix V	Referral Form
Appendix VI	Case Planning Form
Appendix VII	Case Follow Up Form
Appendix VIII	Case Closure Form
Appendix IX	Criteria: Minimum Requirements to be part of the GBV Pathway
Appendix X	List of relevant Ministries and other Government Agencies responding to SGBV
Appendix XI	List of Special Welfare Units - Addresses and other contact details
Appendix XII	List of Security Agencies and Contact Details
Appendix XIII	List of Participating Organisation - Consultative workshop for stakeholders to develop SOP & Validation/Peer Review Meeting

List of Appendices

ACKNOWLEDGEMENT

The Centre for Women's Health and Information (CEWHIN) gratefully acknowledges Professor Ayodele Atsenuwa the consultant who worked tirelessly on this project and her assistant Dr. Folashade Adegbite of the Faculty of Law, University of Lagos. The centre is also grateful to Ms. Lola Rhodes-Vivour of the Domestic and Sexual Violence Response Team (DSVRT) for facilitating the consultations with the stakeholders and other key informants. Gratitude also goes out to the participants of the consultative workshop for stakeholders and the validation/peer review meeting whose contributions were useful in contextualizing this SOP.

Special thanks go to the members of the United Nations Development Programme (UNDP) Spotlight Project Board and members of the UNDP Spotlight Initiative Team – Onyinye Ndubisi (tProject Manager), Matilda Halling (Programme Assistant) for their technical support in implementing the initiative.

We are deeply grateful for the contributions of the project staff; Adebanke Akinrimisi, Atinuke Odukoya, Sumbo Oladipo, Tobi Opadokun and Judith Agada.

AS	Action Sheet
AWLA	African Women Lawyers Association
CBO	Community-based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEHWIN	Centre for Women's Health and Information
CRL	Child Rights Law
CMC	Citizens' Mediation Centre
CMR	Clinical Management of Rape
CP	Child Protection
CRA	Child Rights Act
FBO	Faith-based organisation
FIDA	International Federation of Women Lawyers
FGM	Female Genital Mutilation
GBV	Gender-based violence
GBVIMS	Gender-Based Violence Information Management System
HIV	Human Immunodeficiency Virus
HP	Harmful Practices
IDPs	Internally Displaced Persons
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IEC	Information, Education, Communication
IOM	International Office of Migration
ILO	International Labour Organisation
IPV	Intimate Partner Violence
LGA	Local Government Area
M&E	Monitoring and Evaluation
MHPSS	Mental health and psychosocial support
MISP	Minimum Initial Service Package
NAPTIP	National Agency for Prohibition of Trafficking tin Persons
NFIs	Non-Food Items
NGO	Non-Governmental Organisation
NHRC	National Human Rights Commission
OHCHR	Office of the High Commissioner for Human Rights
OPD	Office of the Public Defender
PFA	Psychosocial First Aid
PSS	Psychosocial Support
PTSD	Post-traumatic Stress Disorder
SEA	Sexual exploitation and abuse
SGBV	Sexual and Gender Based Violence
SOPs	Standard Operating Procedures
SRHR	Sexual and Reproductive Health Rights
STI/STD	Sexually transmitted infection/disease
SV	Sexual Violence
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VAWG	Violence against Women and Girls
VAW	Violence against women
WHO	World Health Organisation

ACRONYMS

CHAPTER 1:
INTRODUCTION

1.1. General Background

Until recently, society viewed gender-based violence (GBV) as a private or family matter. There has, however, been a shift in this thought direction to accommodate the reality that GBV is both a public health problem and a human rights violation. GBV acts are acts of aggression which result in, or are likely to result in physical, sexual or psychological harm or suffering to victims. These include threats or acts of coercion or arbitrary deprivation of liberty, whether occurring in public or private life (United Nations Declaration on the Elimination of Violence against Women, 1993). In GBV, the aim of the perpetrator is to control and/or dominate the victim, particularly when the victim is known to the perpetrator.

Over time, it has been uncovered that it is not just women or girls who are at risk. Men and boys, children and the elderly are possible victims. Similarly, anyone in the society irrespective of social strata can be a victim, whether educated, uneducated, poor, wealthy, widowed or single. Nonetheless, the fact of women's higher vulnerability cannot be overemphasised. The World Health Organisation (WHO) estimates that at least one in five women have experienced violence in their lifetime.

Various groups and organisations including community-based organisations (CBOs), non-governmental organisations (NGOs), Faith Based Organisations (FBOs) and governmental agencies participate in different capacities to assist victims/survivors of GBV find justice and/or healing for their trauma. However, these organisations are often confronted with several issues of "how", "what", "where" and "who". No single organisation can provide the different sets of aid required vby a survivor in the spectrum of facilitating access to justice to healing. Therefore, there is the need for all groups to have a technical document that provides an agreed-to and unified practical guideline that will facilitate better output and ensure that survivors get prompt and effective services in response to their needs

1.2. Background to this SOP

SOPs describe the clear procedures and standards for all actors, outlining roles, responsibilities and present a working manual for those who agree to work together in pursuit of a common interest. SGBV SOPs are developed to assist in creating a coordinated multi-sectoral response, referral and prevention structure for persons at risk.

This SOP is as a one-stop document to provide the response guidelines and pathways for intervenors and other actors (individuals and organisations) responding to GBV and who are known as service providers. It provides information about the proper channels for reporting cases, referrals and facilitating access to justice for survivors/victims of VAWG/SGBV/SRHR/HP in Lagos State. It delineates the roles, responsibilities and procedures for all actors for the best interest of victims/survivors.

1.3. Overview of the Current Situation

Several forms of GBV occur globally based on the imbalance of power relations between different social groups in the society and often, it is rooted in social and cultural norms. The power imbalance may be between the old and young, parents and children, between males and females. Women and girls vis-à-vis men and boys have lesser power over their persons, body, mind and resources.

Generally, social norms and values allow the use of violence to enforce discipline and control; and it is carried out with the intention to humiliate, make an individual or group of individuals feel inferior or subordinate and control their behaviour. Forms of the GBV include physical violence, sexual violence, female genital mutilation, child marriage, intimate partner violence, trafficking for sexual exploitation, female infanticide, stalking, forced marriage, socio-economic violence,.

Several factors have been identified as causally related to GBV and these include the socio-cultural factor, legal factor, economic factor and political factor.and psychological violence.

1.3.1. Cultural Factor

The dominant culture and tradition, which is patriarchal in orientation legitimises male superiority. In turn, this confers legitimacy on the use of violence by the male to control and dominate the female. It stereotypes the female as weak, feeble minded and in need of a firm masculine control and direction.

Culture also often dictates that children should be subordinate to adults and casts a shadow of slight on disability so that people living with disability (PLWD) are treated as inferior to those without disability.

1.3.2. Legal Factor

GBV is underreported because survivors are blamed, stigmatised and regarded as guilty and deserving of the violence. When survivors summon up courage to report, the lackadaisical attitude and lack of empathy of the law enforcement agents encourages a culture of silence. Civil liberties institutions whose aim is to respond to and seek justice for survivors are often constrained in seeking redress by a grossly inadequate legal system.

1.3.3. Economic Factor

Women who form a larger percentage of GBV survivors lack access to economic resources and are not financially empowered. They are often dependent on the provisions for them by the male figures overseeing their lives who may be a father, spouse, partner, uncle or brother. In many cultural arrangements, land which is a vital source of wealth creation is outside the ownership of female. This reality makes females more economically vulnerable to GBV.

1.3.4. Political Factor

Women are underrepresented in politics and power arena; the process of governance and its apparatus are male dominated. Number is especially important in policy making which can effect change in politics; unfortunately; yet women are a minority in politics and power. The insignificant representation of women in politics means that it is often difficult to muster sufficient political power to support needed action including legislative reforms for protecting women against GBV.

1.4. Need for Standardization

It is important for actors to have a common focus and coordinated approach in responding to GBV. Several organisations including government agencies working with GBV survivors may differ in their philosophy, norms and practices in providing services. Attitudes and practices which are not victim/survivor-centered are often counterproductive or outrightly violating of the rights of the victim/survivor. Additionally, actors working around GBV are confronted with a myriad of challenges; some are very subtle yet salient, while others are glaring.

These challenges include:

- Understanding and applying the survivor-centered method which places priority on the rights of the survivor, e.g. the rights to dignity and respect, privacy and confidentiality, non-discrimination and access to information.
- Having a definite understanding and direction of the referral structure to follow and the appropriate response mode.
- Having a clear understanding of the referral pathway for access to justice survivors.
- Managing confidentiality particularly within the social environment which is typified by insecurity, lack of safety and respect for survivors and groups working with them.
- Managing safety and security issues of survivors.
- Handling child survivors, which requires actors to develop a trust relationship with the survivor and display commitment to adherence to the principle of best interest of the child.
- Managing with clear understanding the additional complexities that attend GBV cases involving children and persons with disabilities.
- Integrating survivors into communities for proper adjustment to post-trauma living.

- How to manage and address families' and communities' negative reactions to child sexual abuse.

- Role and extent of media participation in GBV management; whether it is more harmful and encroaching on the safety/security of the survivor; how to avoid excessive media attention and unnecessary interviews.

- Survivor's identification, information gathering and profiling; the limit to questioning to stay within ethical standards.

- Coordination among the various groups and agencies working with GBV survivors for strengthened outcome.

- Having basic knowledge of mandatory reporting and referral laws.

1.5. Objectives of this SOP

To provide an all-inclusive guidance for establishing a procedure that:

- Ensures that survivors and those at risk of GBV receive prompt, efficient and comprehensive response.

- Provides a coordinated response process and a range of support services to meet the needs of victims/survivors, including support and services for psycho-social, medical and legal services and safety/security needs.

- Ensures consistency at all levels of participation for all actors involved in GBV prevention and response.

- Develops structure for monitoring and evaluation while also raising awareness on referral pathways.

- Standardizes the GBV response mechanism in Lagos State.

- Ensures all GBV actors adhere to the best practice and minimum standards that align with international ethical guidelines.

1.6. Scope of this SOP

This SOP provides the guiding principles, procedures for response, prevention and referrals; the roles and responsibilities of all stakeholders working with victims/survivors of GBV such as NGOs, CBOs, FBOs, government agencies and security agencies in Lagos State. The SOP is applicable to all victims/ survivors and persons at risk of GBV – women or girls, boys or men, the elderly and persons with disabilities.

CHAPTER 2:
DEFINITION AND TERMS

The definitions offered in this Chapter are based on common usage of the terms in line with accepted international standards. Where necessary, however, there is some adaptation based on the definitions proffered by the legal frameworks of Lagos State and Nigeria.

2.1.General Definitions

Actor(s): Individuals, groups, organisations and institutions involved in preventing and responding to GBV. Actors may be individuals and communities, government institutions and officials, NGOs, employees or volunteers of international development agencies such as the UN.

Advocacy: The deliberate and strategic use of information initiated by individuals or groups of individuals to bring about change. Advocacy work includes employing strategies to influence decision makers and policies, to changing attitudes, power relations, social relations and institutional functioning to improve the situation for groups of individuals who share similar problems. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Assessment: The set of activities necessary to understand a given situation which can include the collection, updating and analysis of data pertaining to the population of concern (needs, capacities, resources, etc.), as well as the state of infrastructure and general socio economic conditions in a given location/area. In humanitarian settings, NGOs and United Nations agencies often carry out assessments to identify community needs and gaps in coordination and then use this information to design effective interventions. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

'At risk' groups: Groups of individuals more vulnerable to harm than other members of the population because they hold less power, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Community: A group of people that recognizes itself or is recognized by outsiders as sharing common cultural, religious or other social features, backgrounds and interests, and that forms a collective identity with shared goals in a given geographical defined area. (Adapted from A Community Based-Approach in UNHCR Operations, provisional edition, 2008, UNHCR)

Confidentiality: An ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children or clients who express intent to harm themselves or someone else. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Consent / Informed Consent: Refers to approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of the facts, implications and future consequences of an action. To give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given and be able to evaluate and understand the consequences of an action. He or she must also be aware of and have the power to exercise their right to refuse to engage in an action and not be coerced whether by the use of force or threats or threats or the pressure of persuasion. Children are generally considered unable to provide informed consent because they do not have the ability and/or experience to anticipate the implications of an action,

and they may not understand or be empowered to exercise their right to refuse. There are also instances where consent might not be possible due to cognitive impairments and/or physical, sensory or intellectual disabilities. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Coordinating Agencies: The organizations (usually two working in a co-chairing arrangement) that take the lead in chairing GBV working groups and ensuring that the minimum prevention and response interventions are put in place. The coordinating agencies are selected by the GBV working group and endorsed by the leading United Nations entity in the country. (Establishing Gender-based Violence Standard Operating Procedures (SOPs), Gender-based Violence Resource Tools, 2008, IASC Sub-Working Group on Gender and Humanitarian Action)

Disclosure of a GBV incident: The process of revealing information about the GBV experience/incident. Disclosure in the context of gender-based violence abuse refers specifically to how a person (for example, a caregiver, a health worker, a social worker, a member of women groups, a friend, and a teacher) learns about a GBV directly from a survivor. However, the terms "identification" or "involuntary disclose" is commonly used in the case of small children when they are too young to speak about the incident and a third person identifies the violence (a parent, a health worker during examination, and so on). (Caring for Child Survivors of Sexual Abuse, 2012, IRC/UNICEF)

Emergency: A term describing a state. It is a managerial term, demanding decision and follow-up in terms of extraordinary measures. A 'state of emergency' demands to 'be declared' or imposed by somebody in authority, who, at a certain moment, will also lift it. Thus, it is usually defined in time and space, it requires threshold values to be recognized, and it implies rules of engagement and an exit strategy. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Empowerment of Women: The empowerment of women concerns women gaining power and control over their own lives. It involves awareness-raising, building self-confidence, expansion of choices, increased access to and control over resources, and actions to transform the structures and institutions that reinforce and perpetuate gender discrimination and inequality. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Focal Point / Gender-Based Violence Focal Point: Refers to the part-time or full-time role of designated staff who represent their organization, community structures and/or their sector and participate in meeting and coordination activities related to GBV; it also refers to individuals within services and associations who have been appointed as contact person for GBV cases (Guidelines For Gender-Based Violence Interventions In Humanitarian Settings, 2005, IASC)

Gender: Refers to the social attributes and opportunities associated with being male and female and the relationships between women and men and girls and boys, as well as the relations between women and those between men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context / time-specific and changeable. Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. Gender is part of the broader socio-cultural context. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Gender-Based Violence: Is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (i.e. gender) differences between males and females. The term gender-based violence is primarily used to underscore the fact that structural, gender-based power differentials between males and females around the world place females at risk for multiple forms of violence. This includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coer-

cion, or other deprivations of liberty, whether occurring in public or private life. The term is also used by some actors to describe some forms of sexual violence against males and / or targeted against LGBTI populations, in these cases when referencing violence related to gender-inequitable norms of masculinity and / or norms of gender identity. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Health/Medical Care for GBV Survivors: Survivors, especially female survivors, living with and/or having experienced violence may need medical treatment for injuries and mental health services as well as sexual reproductive health services, such as sexually transmitted infections (STI) and HIV testing, prenatal care, contraceptive counselling and provision of methods and other relevant treatment for other common health consequences of GBV. For survivors of sexual violence the essential components of medical care - as defined by international protocols - are: documentation and treatment of injuries, collection of forensic evidence, evaluation for STI and HIV/AIDS and preventive care, evaluation for risk of pregnancy, prevention of pregnancy, psychosocial support, counselling and follow-up. (Clinical Management of Rape, 2004, World Health Organization and addressing violence against women and girls in sexual and reproductive health services: a review of knowledge assets, 2008, UNFPA).

Informed Consent for GBV Survivors: Refers to approval or assent, particularly and especially after thoughtful consideration. Informed consent is voluntarily and freely given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action; and according to the circumstances can be verbal or written. To provide informed consent, the individual must have the capacity and maturity to know about and being enough mentally sound to understand the services being offered and be legally able to give his/her consent. (GBVIMS User Guide, 2011; and WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies, 2007, World Health Organization)

Information Management for GBV programming: The way an organization's information concerning GBV is handled or controlled. Includes different stages of processing information such as collection, storage, analysis and reporting/sharing to ensure security and confidentiality of the data, of the survivors and actors providing GBV services. (GBVIMS User Guide, 2011)

Mandatory Reporting: Laws and policies that mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected child abuse (e.g. physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse). Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC).

Mental Health and Psychosocial Support (MHPSS): This is support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder. An MHPSS approach is a way to engage with and analyse a situation, and provide a response, considering both psychological and social elements. This may include support interventions in the health sector, education, community services, protection and other sectors. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC).

Perpetrator: Person, group or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC).

Post-exposure prophylaxis (PEP): Is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Within the health sector, PEP should be provided as part of a comprehensive universal precautions package that reduces staff exposure to infectious hazards at work. (World Health Organization website http://www.who.int/hiv/topics/prophylaxis/en/)

occurring e.g. by scaling up activities that promote gender equality; working with communities, particularly men and boys, to address practices that contribute to GBV. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Protection: All activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and spirit of human rights, refugee and international humanitarian law. Protection involves creating an environment conducive to respect for human beings, preventing and/or alleviating the immediate effects of a specific pattern of abuse, and restoring dignified conditions of life through reparation, restitution and rehabilitation (UNHCR Master Glossary of Terms, 2006 UN High Commissioner for Refugees).

Psychosocial support for GBV survivors: Services and assistance aimed at addressing the harmful emotional, psychological and social effects of gender-based violence. Psychosocial support seeks to improve a survivor's wellbeing by: i) Bringing healing to survivors and their families; ii) Restoring the normalcy and flow of life; iii) Protecting survivors from the accumulation of distressful and harmful events; iv) Enhancing the capacity of survivors and families to care for their children; and v) Enabling survivors and families to be active agents in rebuilding communities and in actualizing optimistic futures. Psychosocial support focuses more broadly on the individual whereas case management focuses on the immediate needs related to the incident of violence. (Managing Gender-based Violence Programs in Emergencies, 2012, UNFPA).

Psychosocial and recreational activities: Community self-help and resilience strategies to support survivors and those vulnerable to GBV, such as through women's groups/recreational activities. (Managing Gender-based Violence Programs in Emergencies, 2012, UNFPA).

Response for GBV Cases: Response is determined by the GBV survivor's needs and the consequences of the GBV incidents. It means providing services and support to reduce the harmful consequences and prevent further injury, suffering, and harm. Those services should be provided through culturally-sensitive, multi-sectoral care, including health and medical care, mental health and psychosocial support, security/police services, legal assistance, case management, education and vocational training opportunities, and other relevant services.(Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons Guidelines for Prevention and Response, 2003, UNHCR).

Referral Pathway: A flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health and psychosocial support, police assistance and legal/justice support. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Safety Audit: Tool used in visits to emergency-affected areas, comparing conditions against a set of pre-selected indicators about general and specific living conditions of communities and people living in a given area in order to improve safety and security. (GBV Emergency Response & Preparedness: Participant Handbook, 2012, IRC) The audit method varies according to the context. In Syria, safety audits may include observation, focus group discussions, and key informant interviews.

(GBV) Survivor: A person who has experienced gender⊠based violence. The terms 'victim' and 'survivor' can be used interchangeably. 'Victim is a term often used in the legal and medical sectors. 'Survivor' is the term generally preferred in the psychological and social support sectors because it implies resiliency. (Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

Survivor-centred Approach: A survivor-centred approach means that the survivor's rights, needs and wishes are prioritized when designing and developing GBV-related programming.(Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, IASC)

2.2. Incident-Type Definitions

Rape: non-consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. It also includes penetration of the vagina and anus with an object. The attempt to do so is known as attempted rape. Rape of a person by two or more perpetrators is known as gang rape. Date rape is rape that takes place when a person is out on a date with another.

Sexual Assault: any form of non-consensual sexual contact that does not result in or include penetration and it includes attempted rape, unwanted kissing, fondling, or touching of genitalia and buttocks. Female genital mutilation (FGM) is an act of violence that impacts sexual organs, and as such should be classified as sexual assault.

Physical Assault: an act of physical violence that is not sexual in nature. Examples include hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.

Child Marriage/Early marriage: child marriage or early marriage is a formal marriage or informal union in which one spouse is below the age of 18. Even though some countries permit marriage before age 18, international human rights standards classify these as child or 'early' marriages, reasoning that those under age 18 are unable to give informed consent.

Forced Marriage: marriage of an individual against her or his will. Early marriage is regarded as forced marriage because a child cannot give an informed consent to a marriage.

Denial of Resources, Opportunities or Services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is generally included in this category.

Psychological/Emotional Abuse: infliction of mental or emotional pain or injury. Examples include threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

2.2. Other definitions

The definitions below are frequently used in local contexts to provide a more comprehensive picture of GBV and inform response. The definitions are compiled from information of the core type of GBV, the accused/perpetrator, age of the survivor, incident context, and specific cultural practices etc.

Child Sexual Abuse: Is generally used to refer to any sexual activity between a child and an adult or other child. It could be closely between related family members (incest) or between a child and an adult or elder child from outside the family. It involves either explicit force or indirect coercion. It includes different forms of sexual violence.

Domestic Violence/Intimate Partner Violence: term used to describe violence that takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between other family members. Intimate partner violence applies specifically to violence occurring between intimate partners. WHO defines it as behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours. It may also include the denial of resources, opportunities or services.

Harmful Traditional and Cultural Practices: social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include female genital mutilation (FGM); child marriage; the various taboos or practices which prevent women from controlling their own fertility; nutritional taboos and traditional birth practices;

son-preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called “honour” crimes and dowry-related violence, exorcism, or “witchcraft”.

Sexual Exploitation: means any actual or attempted abuse of a person in a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another.

Transactional Sex: is defined by the power relationship between survivor and perpetrator, as well as the circumstances surrounding the incident; underlines whether the sexual violence being reported is exploitative in nature. It also sometimes called ‘survival sex’ when individuals are compelled by circumstances such as limited access to resources to resort to transactional sex to help advance their education, gain employment or business opportunities, or simply to meet basic survival needs. It also includes accepting sex and tolerating physical or sexual violence to sustain relationships, which provide critical income.

Sexual Slavery: indicates whether the incident was perpetrated while the survivor was: a) being forcibly transported (trafficked); b) being forced to join an armed group (forced conscription); c) held against her/his will, abducted or kidnapped.

CHAPTER 3:
GUIDING PRINCIPLES

Guiding principles are the broad philosophy that forms the bases and outlook on which actors may make interventions in GBV. They create the culture and value that direct actors' interactions with victims/survivors and other stakeholders in GBV. Although principles are not enforceable in law, they may have attained international recognitions as best practices and ethical guidelines.
Guiding principles are also usually extracted from human rights instruments and help the development, implementation and monitoring of GBV interventions.

Failure to abide with these principles can have grave and harmful effects on GBV survivors such as increasing their shame, distress and social isolation and further exposing them to more violence. Actors should, therefore, adhere to these sets of principles as they work to cooperate and assist each other in preventing and responding to GBV cases.



3.1 The Survivor-Centered Approach

The survivor-centered approach is a set of principles and skills applicable to all actors irrespective of their roles in preventing and responding to GBV. The approach ensures that survivors have access to appropriate, accessible and good quality services such as healthcare, psychological and social support. This approach aims at providing a supportive environment for the respect of survivors' rights and their dignified treatment. It helps in promoting the survivor's recovery and strengthens his/her ability to identify and express need and wishes; it also reinforces the survivor's capacity to make decisions about possible interventions. Actors applying a survivor-centered approach prioritise the rights, needs and wishes of survivors; hence, it is also a human-rights based approach.

A survivor-centered approach recognises that every survivor:

- Has an equal right to care and support.
- Is different and unique.
- Will react differently to their experience of GBV.
- Has the right, appropriate to his/her age and circumstances, to decide who should know about what has happened to him/her and what should happen next.
- Should be believed and treated with respect, kindness and empathy.

Using the survivor-centered approach, actors should:

- Validate the survivor's experience- it is important that survivor know that his/her story is believed and that he/she is not judged or blamed.
- Seek to empower the survivor- the survivor is placed at the center of the helping process with the aim of empowering them to regain control over their bodies and minds.
- Emphasize the survivor's strengths: the approach seeks to understand and build upon a survivor's inner and outer resources and the inherent resilience.
- Value the helping relationship- it emphasizes that a helper's relationship with a survivor is a starting point for healing. All encounters with survivor must be viewed as an opportunity to build connection and trust.

The main guiding principles are **respect, safety,** non-disclosure and **confidentiality.**

3.1.1 Respect

A GBV survivor's dignity has been assaulted through the incident; therefore, actors should endeavor to restore the dignity of the survivor. Failure to respect the dignity, wishes and rights of survivor can increase the feelings of helplessness, self-blame and shame of the survivor. Actors should therefore adhere to the following principles:

- Respect survivors' dignity, wishes, choices and rights.
- Do not blame survivor for attracting violence to him/her-self and believe his/her story.
- Interviews should be conducted in private settings.
- Ask only relevant questions. Over-critical or over-particular questions should be avoided except it is absolutely required to provide services.
- Interviewer should be patient and not press for more information when the survivor is not ready to volunteer such information.
- The survivor's choice to keep certain information confidential should be respected, until the time he/she wishes to disclose such.
- Female staff should conduct interviews and examinations for female survivors, including translators.
- Male survivors should indicate his preference of a man or woman to conduct his interview.
- Female staff is usually the best to interview and examine small children.
- Avoid asking survivor to repeat story in multiple interviews.
- Simple language that the survivor understands should be used.
- The same Case Manager should handle the survivor's meetings and interviews throughout his/her case management process.

3.1.2 Safety

This refers to the physical, emotional and psychosocial safety of survivors.

- Safety and security of the survivor and that of his/her family, where applicable should always be ensured.
- Maintain consciousness of the safety and security of service provider and any other persons helping the survivor such as friends, family members, healthcare givers etc.
- In documenting, reporting, monitoring and case management, ensure that the risks are not greater that the benefits to the survivors.
- Service providers should bear in mind that a survivor may be at further risks from the perpetrator, people protecting the perpetrators and members of the survivor's family due to notion of family 'honour'.

3.1.3 Confidentiality

Confidentiality should be maintained through strict information sharing practices that rest on the principle of sharing only what is absolutely necessary to those involved in the survivor's care with his/her permission.

- Respect the privacy of the survivor and his/her families at all times.
- Information obtained from survivor should be kept confidential at all times.
- Informed consent of the survivor must be obtained before his/her information can be share.
- For purposes of help or referral, when informed consent of survivor is obtained to share information, only pertinent information should be shared.
- In the instance that the survivor cannot read and write, an informed consent statement should be read to him/her and a verbal consent should be obtained.

- All written or recorded information of survivors must be securely kept against unauthorised access.
- If any report or data are to be made public, name, address etc. should be withheld in the compilation, reporting and sharing of data.
- Ensure privacy before interviews starts with survivors. A secured and conducive environment that will give the survivor the sense of safety, security and privacy.
- Accurate information on available services, access to such and the potential risk and consequences of such services should be made available to survivors.

3.1.4 Non-Discrimination

Every survivor has the right to the best possible assis-

- There should be no discrimination in all interactions with survivors and in all service provision.
- Survivors should be fairly and equally treated irrespective of nationality, ethnicity, religious, cultural and sexual orientation.
- Survivors should be accorded the high level of regard; condescending, judgmental or disrespectful attitude should never be shown to individual or his/her person, culture, background, family or situation.

3.2. Guiding Principles

Organisations should familiarise themselves with and follow the ethical and safety recommendations in the WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (WHO, 2007). Organisations that agree to this set of guiding principles should:



- Collaborate and cooperate between each other in preventing and responding to GBV.
- Ensure that staff, volunteers and ad hoc workers within their organisations are committed to integrating GBV into their operations and are adequately skilled to do. Staff and volunteers are also to adhere to all ethical and safety standard for research, documentation, and monitoring in GBV interventions.
- Integrate and maintain GBV interventions into all programmes and all sectors.
- Ensure accountability at all levels.
- Engage communities to fully understand and promote gender equality.
- Establish and maintain careful coordinated multi-sectoral and inter-organizational interventions for GBV prevention and response.
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analyses and assessment information to avoid duplication and to maximize a shared understanding of situations.

- Ensure equal and active participation by women, girls, men and boys in assessing, planning.
- Implementing, monitoring and evaluating programmes through systematic use of participatory methods.
- Engage the community fully in understanding and promoting gender equality and gender power relations that protect and respect the rights of women and girls

3.3. Guiding Principles for Working with Specific Survivors

In addition to the guidelines provided above, additional guidelines and principles apply for these categories of GBV survivors in providing response and services to them.



3.3.1 Children

- The Best Interest of the child should be the overriding consideration in handling a child-survivor. In arriving at the best interest of the child, factors such as age, sex, cultural background, family background, past experiences and general environment should be taken into consideration. To this end, actors should adhere to the spirit and content of the Child Rights Law and seek professional advice from experts.
- The rights of the child should always be upheld in providing services, including their right to participate in decision making that will affect them.
- The child must be consulted and given all the information he/she needs to make an informed decision. Ability to provide consent depends on the age, mental capacity and maturity of the child-survivor and capacity to express him/herself. In the event of the decisions of the child not being in his best interest, the service provider should through a transparent manner take the child through the process of a better decision.
- Ensure the physical and emotional wellbeing of the child (both in the short and long term). In deciding the course of response, the least harmful course is always preferred.
- The child should be encouraged to express him/herself through the use of child-friendly techniques.
- The child should be listened to and believed; paying particular attention to their concerns and fears helps the child to feel secure.
- The interviewer should be empathetic.
- Interview should be in a friendly manner so that the child will speak in his/her own words, the child survivor should be helped to express him/herself. Interview can be recorded.
- When appropriate, there can be multi-disciplinary team around to listen to the child survivor.
- A child-survivor may be frightened and needs assurance of his/her safety, ensure the child is safe at all times, ensure that he/she is not placed in a situation of further risk of harm. Children, who disclose sexual abuse, need to be comforted, encouraged and supported. They should not be blamed for the incidence.
- Carry out a safety assessment for help from people who can provide security, such as police, elders and leaders within the community etc.
- Let the child know and understand that the information supplied by him/her will only be shared with their caretakers or other appointed legal guardian where it is safe to do so and if it will ensure the safety and security of the child.

- In instances where the law prescribes mandatory reporting, the child and his/her caregiver should be informed of this at the beginning of the process and carried along.
- Informed consent of the legal guardian of the minor must be obtained prior to any response service or sharing of information. Where, however, the perpetrator is the legal guardian or has the support of the legal guardian, this requirement should be waived.
- All children should be treated fairly and equally. No child should be treated unfairly for any reason.
- Assist children to heal and strengthen their resilience as each child has the capacities and strength to heal. As such, the service provider should build upon the child and family's strength as part of the recovery and healing process.

3.3.2 Girls & Women

- For victims/survivors of sexual abuse, particularly rape, provide first line support response such as medical care which may help in preserving evidence and preventing post- exposure prophylaxis such as HIV
- Minimize further trauma while interviewing and taking history.

3.3.2 Boys & Men

Male victims/Survivors of GBV require additional guideline in service providers' response to the ones listed above perhaps because of cultural perspective of 'manly strength'. Though response to male survivors is similar to the above listed one, these additional considerations should be included:

- Service Provider must acknowledge that men and boys can be victims of GBV and as such require response and care. Service Provider should encourage the man/boy to freely express himself without giving him a condescending attitude.
- Make them realize that men and boys can be victims of GBV, and that seeking help is the right thing to do.
- They should be believed and made to feel safe and cared for.
- They should not be shamed or made to look less 'manly' for their disclosure.
- Build their trust; let them know that their case will be handled confidentially. This is particularly important to men.
- Allow Male survivors choose the service provider they feel comfortable with.

3.3.4 People with Disabilities

People with disabilities are one of the most vulnerable of GBV survivors. WHO reports that persons with disabilities experience violence 4 to 10 times more than people without disabilities. Perpetrators of these abuses are often family members and people close and known to the survivor. The situation is more precarious for people with mental health challenges such as schizophrenia, post-traumatic stress disorder (PTSD), chronic depression etc. or intellectual impairments such as autism, ADH disorder, Bipolar, Down's syndrome, Fragile X Syndrome, etc

People with disabilities have the right to access to GBV services without discrimination. Hence, aside the general guidelines which should be duly considered in providing response to persons with disabilities in GBV programmes, additional guidelines include:..

- Respect for the principle of participation and inclusion in treating persons with disabilities. This principle aims at engaging persons with disabilities in wider society and in making decisions that will affect them. It also encourages them to be active in their own lives within the community.
- Focus should be on the whole person and not the survivors' disabilities. People with disabilities have identities such as mothers, friends, leaders, neighbours, etc.

- Support people with disabilities to develop their own sense of agency and power to make their own decisions. However, do not assume for a survivor with disability what they want or feel; rather explore with them to identify their concerns and interests and give them opportunities as is given to other GBV survivors.

- In responding to persons with disabilities, work with their family members (non-perpetrating) as well to identify their skills and capacities, using this to inform, implement and evaluate the GBV programme that will be designed for them.

- Ensure physical access and adapt office environment e.g. entrance and other physical structure within and around the GBV actors and service providers to accommodate needs of people with disability, e.g. having a ramp at the entrance.

- Specific considerations need to be considered while communicating with people with disabilities and/or providing services to them. Make provision for experts and professionals to aid communication with people with special communication needs.



Survivors with physical impairment

- Survivors with physical impairment should be met in places that are easily accessible to them and with adequate privacy.

- Discuss transport options for activities and events. Consider what is going to be the safest, most affordable and the least amount of effort for the individual and family.

- If survivor is using a wheelchair, interviewer should sit at the survivor's level.

- Be sensitive about physical contact.

- Do not lean or move survivor's wheelchair or assistive device without their permission.



Survivors with hearing impairment

- Inquire for the preferred means of communication and use preferred option. Some survivors may use lips-reading while others use simple gestures or communicate through writing.

- Find out whether the survivor understands and uses sign language and make effort to provide the specialist.

- The survivor should be allowed to sit in the place he/she chooses or prefers to sit to put him/her at ease.



Survivors with visual impairment

- The staff/personnel of an institutional service provider should always introduce self and organisation to the survivor.

- Pictures, written documents and vague languages should be avoided. If it is necessary to use any of such, the content should be described in as much detail as possible.

- Always tell the survivor you are moving or leaving their space – do not just walk out.

- It is good to give an initial tour of the environment to this category of survivor at their first visit to make them feel comfortable.



Survivors with intellectual impairment

- Sentences should be short and easy so as to communicate a point at a time.

- Questions may need to be repeated using other sets of words which may better describe what you are trying to communicate.

- Always give sufficient time for response.

- Be patient and make sure the survivor is not rushed.

- Interviews and discussions should be held in conducive environment to reduce distractions
- Pictures can be used to communicate to survivors with intellectual impairment.
- Adults should be treated as adults and not as children.



Survivors with speech impairment

- Always allow a survivor to complete his/her statement; avoid the mistake of completing it for him/her.
- More time is needed for proper communication with survivors with speech impairment, so plan for it.
- Never assume, always ask a survivor to repeat the point if you do not understand and narrate it back to confirm that you got the right narrative. The use of questions with short and direct answers – Yes or No - is useful.

CHAPTER 4:

IDENTIFICATION OF VICTIMS AND DISCLOSURE

Disclosure is when an adult survivor chooses to share his/her GBV incident to someone while identification refers to the situation where other persons inform service providers that another individual has experienced GBV.

Disclosure could be to anyone including family members, friends, peer, Community leaders, School teachers, Police or Security personnel, NGOs/CBOs/FBOs, Healthcare providers or anyone whom the survivor perceives can be of help.

When an actor who is not a GBV specialist receives a report identifying someone as having experienced violence, they should contact a GBV specialist who has experience in implementing appropriate steps and follow-up. A survivor has the right and freedom to report a GBV incident to anyone he/she chooses.

Actors in non-GBV areas are the entry point to GBV referral pathways for survivors who disclose GBV incident and need referral. It is therefore important that all actors understand and comply with this disclosure procedure.



If at the point of entry, the Actor who is not a GBV specialist is unsure of how to proceed, he or she should consult a GBV specialist without disclosing identifiable information about the survivor's situation; and in situations where a GBV specialist is not available, the non-GBV specialist should follow the Guiding Principles outlined in this SOP to ensure that the survivor is not left without service.

All organisations and actors, including those are not specialised in providing GBV services should prepare and train their staff/volunteers on GBV guiding principles and standard operating procedures relevant to their specialisation.

An actor who receives a disclosure of GBV from a survivor, should provide the survivor the following:

a. Psychosocial First Aid.
b. Information on services that are available to the GBV survivor.
c. Details on how to access these services.
d. Appropriate support to help the survivor access these services.

4.1 Handling Disclosure

In handling disclosure from a survivor of GBV, an actor should BE MINDFUL of the following:

- GBV survivors' needs are numerous; therefore, coordination amongst service providers is important in meeting these needs. Service providers must maintain functional referral system to be able to provide timely access to quality service for survivors.

- Actors have the duty to provide objective and comprehensive information on services and options available in the community to survivors who approach them. It is essential that the full range of choice for support services should be presented to the survivors regardless of personal beliefs

- The Actor may refer survivor, as he/she requests, to service providers as per the agreed upon referral system in Lagos State including health, psychological, security and legal services and should provide assist the survivor through the referral process in the service provider. For

example, the Actor should escort the survivor to the referred service provider or facilitate the survivor's access.

- In cases of sexual violence and/or bodily injuries, health assistance is the priority, particularly the first 72 hours. Assistance rendered from case to case must be in accordance with best practices or relevant Guidelines. For example, assistance rendered in the case of rape should follow the WHO Clinical Management of Rape and Intimate Partner Violence Guidelines, 2020 which includes the provision of emergency contraception and post-exposure prophylaxis for HIV.

- Service providers should inform the survivor of what assistance they can offer and clearly relate what cannot be provided or the limitations to services, to avoid creating false expectations.

- All service providers in the referral network must be knowledgeable about the services provided by any actor to whom they refer a survivor.

- Children must be accompanied to all services within the referral pathway.



4.2 Steps in Disclosure Procedures

PREPARE

Be aware of available services.

Know how to communicate with survivors in a survivor-centered manner.

Increase your knowledge and skill as a non-GBV service provider

WELCOME

Find a safe and quite space to talk

.

Ensure they are not left alone.

Ask the survivor what their immediate concerns are.

Assess the security and safety of the survivor, evaluating this together.

Remove the person from immediate danger, identify together actions to help (key people to contact, safer locations).

If the survivor is a very distressed, help them to calm down.

Ask what the survivor needs to be comfortable (clothing, food, water etc.)

Ask if you can provide help

LISTEN

Act in a respectful manner to build trust with the survivor and listen to them.

Allow the survivor to disclose their distress and seek help.

Do not pressure the person to talk and do not expect them to display particular emotional reaction.

Listen in case they want to talk about what happened.

Listen actively (e.g. give your full attention, gently nod your head, make eye contact, use appropriate body language).

Assure survivor that it is common to feel strong negative emotions in these situations.

PROVIDE INFORMATION

Inform the survivor they are entitled to protection from violence, abuse and exploitation, and to receive care and support.

Inform the survivor of services available, and the benefits and consequences of the available options.

Use language they will understand.

Inform the survivor of a realistic timeframe within which services can be expected. If you do not know, contact the service provider to find out.

For sexual violence survivor, provide information on health services.

Explain to the survivor the importance of seeking healthcare within 72 hours to minimize risks of sexually transmitted disease (including HIV/AIDS) and unwanted pregnancies.

For adult survivors, inform them they have the right to decide what service they wish to receive and with whom they wish to share information.

Give the survivor time to take breaks and ask for clarification.

Respect the survivor's right to decide what support he or she need.

Do not impose advice or opinion on what the survivor should do

REFERRAL

If survivor requests or consents to access service, follow this SOP's procedure for referral.

Refer the survivor to a GBV Case Management service provider, if available in your location for follow up

CLOSE

Finish the disclosure in a positive way.

Reaffirm to the survivor that he or she are entitled to protection from violence, abuse and exploitation, and to receive care and support.

Reaffirm it is not their fault.

Reaffirm it is common to feel strong negative emotions in these situations.

Reaffirm to the survivor that he/she has the right to live free from violence and risk of violence.

4.3 Sample Healing Statements

(culled from Kurdistan Region, Iraq, p.23)

- Build relationship / rapport
  "Thank you for sharing that with me" / "I'm glad that you told me"

- Empathy
  "I'm sorry to hear what happened to you" / "I'm sorry to hear you are going through this"

- Trust
  "I believe you"

- Reassuring & Non-Blaming
  "What happened to you is not your fault" / "You did not deserve what happened to you"

- Empowering
  "You are very brave to talk with me and I will try to help you."

- Confidentiality
  "I want to let you know that what you shared is confidential and I won't tell this to anyone else without your consent"

CHAPTER 5:
REPORTING AND REFERRAL

This chapter gives details on what GBV and non-GBV service providers can do when a survivor reports an incidence of GBV to them. In providing services, providers should take note of the following:

- GBV actors must maintain functional referral systems that will provide timely access to quality service for GBV survivors.
- In creating and maintaining referral structures, it is important that the survivor should be able to have access to service provision through any entry point of his/her choice. There should not be a designated first point of contact; rather, here should be multiply entry points from which the referral system proceeds.
- The service provider that receives the initial disclosure from the GBV survivor should recognise that the survivor has the freedom to choose whether to seek assistance, the forms of assistance, and from whom to seek the assistance.
- Service providers should clearly provide information to the survivor on the assistance they can render and those they cannot render so as that the survivor does not have wrong expectations of them.
- All service providers within the referral network must be aware of the services being provided by others to whom they refer a survivor, whether or not they are first point of contact for a survivor.
- Children must be accompanied to all services within the referral pathway.
- There should be a 24-hour (including weekends) all round service provision of accommodation for child survivors.
- Children in need of temporary accommodation should not be denied under any procedural guise. Immediate needs of such a child survivor should be the overriding consideration. Perfection of process can always be done after the immediate safety and security of the child has been ensured.

Factors that should be considered in evaluating services to which a survivor will be referred are:

- Presence: Whether the service is regularly available and fully functional.
- Geographical Location: The proximity of the service to the survivor.
- Accessibility: How the survivor and/or communities can access the service freely, safely and confidentially.
- Availability: The forms of services available
- Accountability: The persons/group responsible for following up the service.

5.1. Information sharing during Referral: Consent and Confidentiality

During referrals, actors need to share information about the survivor and the GBV incident. However, such information is extremely sensitive and confidential, and needs to be well-managed. It is not impossible that such information can have serious and potentially life-threatening consequences for the survivor and those assisting him/her. The survivor has the right to control how the information about his/her case is shared and with whom it is being shared. Further, his/her consent must be obtained before steps are taken in handling the GBV incident being reported. Asking for informed consent from the survivor means asking for permission to undertake any action (including referral) and to share information about them to others. The informed consent of the survivor should also always be obtained in sharing of information and such information should also be kept confidential by the forwarding actor and the receiving actor.

5.2. Informed Consent

Informed consent can only be said to be given when an individual agrees to participate in an activity or to allow something to occur after he/she has knowledge of or has received all the information about the activity. For the consent to be termed informed, the individual must:

1. Have all the information needed to reach such consent;
2. Be of legal age to make or give the consent;
3. Have mental capacity to understand the agreement and the consequence;
4. Must possess equal power relation with the person asking for the consent.

In obtaining the informed consent of a survivor, actors must ensure that:

- All relevant information and options are made available to the survivor (or in the case of a child, the parents/trusted caregiver/guardian) in order to give his/her informed consent. This information should include the implications of sharing information about case with other actors and the options/services available from the different agencies.
- All possible pros and cons of the situation are discussed.
- Consent is given voluntarily without any force or coercion.
- It is obtained by an individual that the survivor is comfortable with.
- It is taken in a place where the survivor is comfortable.

  Consent should be taken in writing where legal and medical services are provided.
- Informed consent from minor survivor would need to be taken in consultation with
- Parents/guardians (non- perpetrating) who are acting in the best interest of the child.

There is no consent when agreement is obtained through the use of force, fraud, abduction, coercion, manipulation or misrepresentation. Also, there is no consent when threat to withhold benefit to which the survivor is entitled to is used and/or a promise is made to the survivor for further benefit.

However, in very exceptional circumstances, informed consent of the survivor can be done away with especially when:

i A survivor is suicidal.

ii A survivor threatens to seriously harm other people.

iii Child abuse or neglect is suspected, and it is in the best interest of the child

iv When mandatory rules apply.

When a survivor does not give consent, his or her information should not be shared with other organisations or service providers, but such survivor is still entitled to receive appropriate and timely care.

5.3 Children and Consent

Permission to proceed should be sought both from the child and their non-perpetrating caregivers (parents or guardians) and the informed consent should be obtained although, identification as opposed to disclosure is more common with GBV child survivor. In obtaining the informed consent of a child survivor, the guiding principles explained in the Chapter 3 MUST be adhered to.

5.4 Use of Consent Forms

Consent forms should be used by GBV specialists within the framework of case management when referring the survivor to specialised GBV service.

The survivor should sign the form when necessary to show they agree to the services they are being referred. For survivors who are unable to sign, thumbprint should be used or an 'X' be placed in the appropriate place or verbal consent be obtained. The survivor should be made to understand how service provider will store and disseminate the information. Signature of the survivor may not be appropriate when it will pose risk to the safety of the survivor. A suggested template of the Consent form is in Appendix I.

Steps to follow in obtaining the Informed Consent of a Survivor

STEP 1: Provide and Explain All Information

All possible information and options available should be provided to the survivor. This should also be explained to him/her in simple language he/she can understand.
Survivors should also be informed that they have the right and freedom to decline or refuse any aspect of any services being offered.

STEP 2: Ensure the survivor understands the implications of any referral

The benefit and risk attached to the services should also be explained to the survivor. The survivor should also know that he/she has the right to control what information will be shared, how it will be shared and whom it will be shared with.

STEP 3: Explain limitation to confidentiality

The survivor should be made to understand that there is need to share information to others who will provide additional services

STEP 4: Ask and obtain consent

The survivor should be asked directly for consent to contact other service providers and to share certain information.

STEP 5: Check limitation of consent

Attention should be paid to whether the survivor placed a limitation on the types of information to be shared and to whom

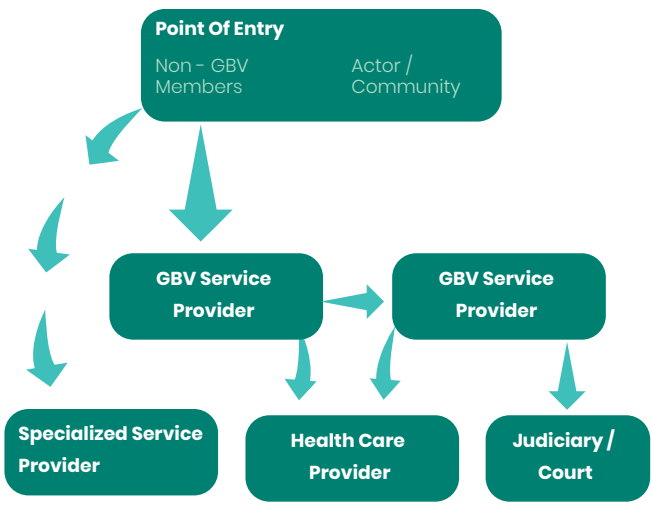
5.5 Referral Options

Two options are opened to a survivor who chooses to access support, and he/she should be informed of these two options. The actor should provide survivor with information of where services are available or if the survivor chooses the second option, should be refer after obtaining necessary consent

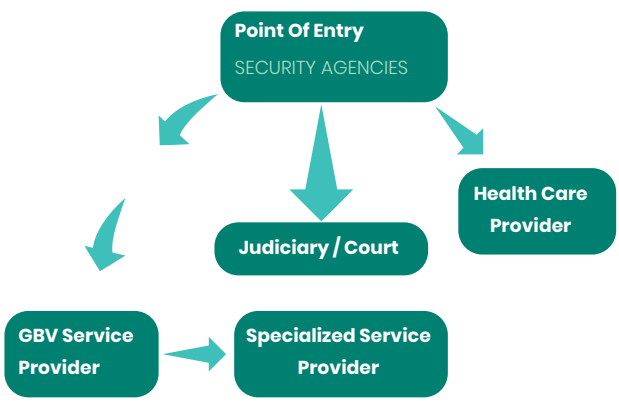
5.6 GBV Referral Pathway/Directory

This provides information and details of organisations and specific service providers or professionals and their contact details. The individual or organization who is the first point of contact for the survivor should act in accordance with the referral structure and this includes respecting the freedom of the survivor to withdraw from services at any stage of the process. Information must be provided to survivors on the type of services available and how to access them and refer survivors to those services. Referral pathways differ for organisations that are GBV specialist and those that are not.

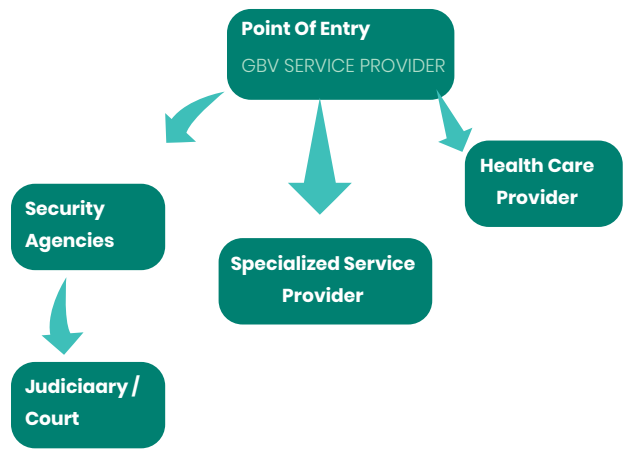
5.6.1. Type One Referral Pathway



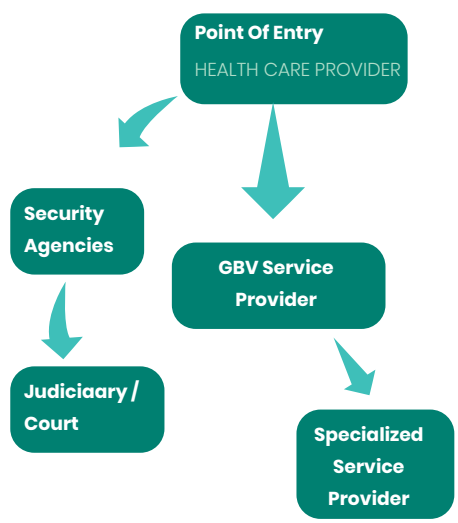
5.6.2. Type Two Referral Pathway



5.6.3. Type Three Referral Pathway



5.6.4. Type Four Referral Pathway



5.7 Building Referral Pathways for an All-inclusive Response

It is important that the various categories of actors in the GBV response should have a comprehensive **RFERRAL DATA BASED DIRECTORY** for easy and accessible referral pathways. In achieving this therefore, the various sectors within the actors:

- Must be aware of the assigned police station covering its area to which referral can be made when needed and should maintain an active link with the local police station.
- Should create a Referral Data Base Directory and it can include services and professionals related to:
  - a Legal and Medical Aid
  - b Police Stations and Area Commands
  - c Financial Aid Services
  - d Mental Health Services (psychologist/-psychiatrist)
  - e Government Remand Homes
  - f Government and Private Orphanages and Shelters/Hostels
  - g Community-based and national NGOs
  - h Institutions dealing with chemical/drug dependency and rehabilitation
  - i Hospitals – government and private within the actor's vicinity
  - j Vocational Training Institutes
  - k Social Welfare department
  - l Schools in the area
  - m Local Government Officials
- Should create linkages and rapport with the media to ensure prompt support for the cases where survivors choose to share their stories. In doing this, all the guiding principles for survivor-centered approach should be observed. The privacy and anonymity of the survivor and persons related to them should be respected. As such, photographs of survivors should neither be taken nor made public.
- Should create and maintain active link with local government, hospitals (primary and secondary healthcare facilities).
- Should network and keep robust relationship with other GBV and non-GBV service providers.
- Visit those identifiable referral services to assess their facilities, qualities and sensitivities to survivors, particularly, women and children and issues affecting them.
- Make sure that the Referral Directory is regularly updated, and re-referrals should be made on the basis of feedback from referred survivors.
- Where necessary and possible, have a formal Memorandum of Understanding (MOU) signed with referral services/professionals.

5.8 Steps in Making Referrals

STEP ONE INFORMATION, AGREEMENT AND INFORMED CONSENT

Information should be given to the survivor about possible referrals for services in a safe, ethical and confidential manner.

Prior to any step of referral, survivor's agreement should be obtained, and informed consent for information sharing should be obtained.

NOTE: The survivor has the right to choose to which service for referred and to ask for limitations on the shared information.
Prior to any step of referral, survivor's agreement should be obtained, and informed consent for information sharing should be obtained.

STEP 2: INTAKE

- Survivor should be interviewed in a safe and confidential way, obtaining more details to get a good understanding of incident.
- Personnel collecting information from survivor should be appropriately trained in following the guidelines, and should carry out this duty with compassion, confidentiality and with respect to the survivor.

  Provide complete and correct information about service providers, i.e. Who (which institution/organisation provides services to GBV survivors, adding contact information or a person (name, telephone number) that can be reached as an entry point to that service); What (what sort of assistance survivor can expect to receive from a specific service provider, adding cost information related to that service); Where (the exact address of the indicated services).

NOTE: Do not raise the survivor's expectations by giving false information/impression which you will not meet

STEP 3: SAFETY ASSESSMENT

- It is important that all actors jointly do an assessment of further risk of violence to survivor; this will assist in planning for appropriate referral and increasing survivor safety

STEP 4: ASK AND OBTAI CONSENT

- Survivor should thereafter be referred to the appropriate service provider.
- To avoid survivor having to repeat stories and multiple interviews, referral should be accompanied by a short, written report and telephone discussion with the other service provider.

STEP 5: ACCOMPANY

- In suitable situations, the survivor should be accompanied to the referred service provider.

5.9 Mandatory Reporting

A survivor has the freedom and right to disclose or not, and this should be respected. However, there are instances in which a person receiving a GBV report is required to report. One of such is incidents of sexual exploitation.

- All actors should be familiar with the relevant Lagos State law and policies and their organisation's internal policies regarding reporting cases.
- Service provider should inform the survivor about the duty to report certain incidents in accordance with laws or policies or if there are concerns for the safety and security of the survivor.
- Service provider should explain the reporting mechanism to the survivor and what they can expect after the report.
  The incident should be reported with the survivor's consent.
- The informed consent of the survivor should be obtained, although the survivor has the right not to be involved in the reporting and investigating process of the case. When the survivor wishes not to be involved, referral should be made concealing his/her name and identity while access to service should still be prioritised.

5.10 Media Reporting

Publicity or media reporting is not the usual course of response and can be used only in exceptional instances where it will add meaningful value to justice and healing of the survivor. In giving publicity to any GBV case, a service provider must ensure that the survivor is at the stage when he/she can make an informed decision about being involved in or granting permission to such media reporting.

Instances when media reporting may be useful is when some survivors decide to help break silence and assist others. Further, publicity can be used when the survivor requests for it despite being informed of the possible negative repercussions. The following considerations are recommended before going ahead with media reporting or publicity:

Before a report is made to the media, thewritten consent of the survivor (or non-perpetrating parents or guardian in case of children) must be obtained and the survivor should be adequately informed of the possible implications of revealing their case to the media.

In case a public statement is required to be made regarding a case, any such statement should be given with both the verbal and written consent of the survivor (or non-perpetrating parents or guardian in case of children). The service provider should appoint one staff member who acts as the focal point of contact with the media.

The survivor must never be used for advancing the interest of the activist(s)/supporter(s) or the service provider(s) or organisation(s). Using a survivor in such a manner is highly unethical; and it is also a form of exploitation and must never occur.

- Stories or image that might put the survivor, his/her siblings, peers and other concerned relatives at risk, should not be published, even when identities are changed, obscured or not used.
- When names and images of survivor are not used in the media, details that will easily give away his/her identities such as address, school, etc. should not be used.
- Ensure that the media do not further stigmatise any survivor; avoid categorisation or descriptions that expose a survivor to negative reprisal – including additional physical or psychological harm, or to lifelong abuse, discrimination or rejection by their local communities.
- When there is a press conference or media interview, survivor should be prepared for possible kind of questions and also be apprised of his/her right to refuse questions he/she does not wish to answer.

5.11 External Reporting

Reporting to other external actors and organisations e.g. progress reports to donor, policy papers, or government should be done adhering strictly to the guiding principles about privacy and confidentiality. Such reports should not contain confidential and identifying information about survivors. Also, such report should not contain information that may pose as risks to safety and security of the survivor and service provider, if it gets into the wrong hands.



CHAPTER 6:
ROLES AND RESPONSIBILITIES FOR SURVIVOR ASSISTANCE

This chapter specifies the roles and responsibilities of specialised actors in dealing with GBV cases. Specialised actors can receive cases either through disclosure from survivors or through referral from other actors. In dealing with GBV, all specialised actors should ensure that the frontline serves are accessible, private, confidential, safe and trustworthy.

Some survivors of GBV may not be in need of these specialist services. However, some others want and need the assistance such as psychological first aid (PFA) and clinical health interventions which are delivered through multi-sectoral approach in accordance with the international standards and protocols. A multi-sectoral response to GBV is a holistic and coordinated approach directed at harmonising and correlating programmes and actions developed and implemented by a variety of institutions and actors.

The needs of GBV survivors differ. They are not only different in dimensions, but some are also immediate and prompt, while others are in phases and may be needed on short or medium and even long term. Survivor may have immediate needs such as basic assistance to ensure their wellbeing, safety and security. These include material needs like food, non-food items (NFIs) and shelter which should be arranged by GBV service providers through quality and timely referrals to non-GBV service providers. In instances when GBV survivors need it, Dignity Kits should be provided for immediate use. (See Appendix III).

The needs of GBV survivors differ. They are not only different in dimensions, but some are also immediate and prompt, while others are in phases and may be needed on short or medium and even long term. Survivor may have immediate needs such as basic assistance to ensure their wellbeing, safety and security. These include material needs like food, non-food items (NFIs) and shelter which should be arranged by GBV service providers through quality and timely referrals to non-GBV service providers. In instances when GBV survivors need it, Dignity Kits should be provided for immediate use. (See Appendix III).



In providing immediate assistance to survivor, actors should take the following into consideration:

- Survivors should not be exposed to further risks and dangers; assistance should be closely guided by the principles of confidentiality, safety, respect and non-disclosure.

- It is better to identify a safe and easily accessible space that allows for privacy to meet survivor. Home visits are not recommended when supporting GBV survivors except it is agreeable to survivor and it poses no risk to the survivor or service provider. Home visit may put the survivor to more risk and/or stigmatization. However, in instances when home visit is essential, strategies should be put in place to minimize the risk to survivors and service provider. Discreet and low profile should be the watch word. The following can help in minimizing the risk:

i Multiple households including the survivor's household can be visited at a time to provide information or some other non-GBV related types of services to those other household. By doing this, attention will not be drawn to the survivor.

ii Know the day and time to visit the survivor; the day and time that will be most conducive to the survivor and form of help to be rendered, for example when there will be fewer members of the community around and/or when perpetrator will not also be around or near the house.

iii Having a signal and/or code with the survivor to signal presence or absence of risk and danger to stop visit or cut short visit. Mobile phones can be used when available or other objects such as cloths, sticks etc. that will signal that visit should not be done or that it is not safe for discussion.

iv If it is anticipated that the survivor may be confronted about service provider's visit, discuss with such person what they can say to others about your person and purpose of your visit so as not to expose themselves to risk.

v You need to be sensitive in requesting for information from the survivor in the presence of relatives or members of the community; this might have impact on the survivor's protection.

vi Home visit should not be used to identify GBV cases. GBV actors should not go out in communities to actively identify GBV cases. Outreach teams can visit homes and communities to provide general information on services available but such visit should not include questions or discussions about personal experience of violence within the household.

6.1 Health and Medical Response

Medical and health caregivers are important in cases of GVB and are often the first responders. They treat injuries, conduct thorough medical screenings and forensic examinations, provide psychosocial support, and provides treatment which prevent further harm and health consequences. They are often generally the first point of call to provide appropriate referrals and follow-up. Medical response and health caregivers include private sector caregivers.

Medical and health care providers should identify staff who are the first points of contact when a survivor enters the health facility and such should be trained in the survivor-centered approach in all health assistance to protect GBV survivor. Such health care staff:

- Should be well equipped with the basic and immediate psychosocial support to facilitate the treatment of the survivor, including trauma counseling.
- Should never determine whether a legal offence e.g. rape or sexual assault occurred; this is largely a legal issue for determination by the legal actors.
- Should know the relevant protocol to use in the care of GBV survivors in line with internationally approved standards e.g. standards relating to the clinical management of rape (CMR) survivors.
- Provide medical care, record details of the history and the physical examination and other relevant information.
- Collect forensic evidence; this should be done with the survivor's consent (or parent/guardian)
- Should know and understand the importance of other services including legal and social services when responding to GBV.
- Should have a constructive and professional relationship with other service providers and

- actors assisting the survivor or investigating the crime. Networking with other service providers can help ensure comprehensive care.
- Should be free of prejudice or bias in dispensing their roles and should maintain high ethical standard in the providing their services.

NOTE: Every health facility should have a link with a Child Protection Service to ensure that it is able to draw on or provide referral to specialist services.



Table below shows the response and preventive` roles of healthcare provider

RESPONSE	PREVENTION
Examine survivor, history taking and basic counselling Provision of needed treatment based on the individual needs of GBV survivors. Completion and provision of medical reports and any necessary evidence. Refer to relevant service provider (check the referral pathway). GBV health service provider will give evidence in court when appropriate and required. Provision of health care, if needed for perpetrator(s)	Training of all health care givers on GBV response and SEA awareness Sensitizing health care personnel on GBV and SEA issues as part of health education. Health care providers who accede to SOP should send representatives to joint meetings on GBV with other actors. Health care facilities should have policies that ensure that perpetrators seeking healthcare are not discriminated against.

6.1.1 Sexual and Reproductive Health for GBV Survivors

- Women/Girl survivors should have access to a full range of health services including sexual and reproductive healthcare beyond the clinical management of rape and/or sexual assault.
- Women/Girl survivors should not be shamed or stigmatized for their choices of sexual/ reproductive health.
- Women/Girl survivors have autonomy over their healthcare decisions and do not need consent from male relatives, guardians or husband to receive health care or referrals.
- For sexual/reproductive health provisions such as contraception, family planning and STI management, health care providers should not require for the consent of a male guardian before providing women and girls with services.

NOTE: Elective abortion is allowed in Lagos State for therapeutic reasons – that is, to save the life or health of woman or girl survivor. The National Guidelines on Safe Termination of Pregnancy for Legal Indications (2018) adopted by the Federal Ministry of Health provide helpful guidance.

6.1.2. Special considerations for Child Survivors

Some special considerations that must be noted in the providing services to a GBV child survivor are:

- Before a health care service provider examines a child survivor, the procedure for care and treatment should be explained to the child (and his/her non-perpetrating parents/guardians); and consent for each stage should be obtained. When the parent/guardian is the perpetrator, then the police or representative from the GBV service provider may sign the consent form.

  NOTE: generally, child survivors should not be compelled to undergo an examination or treatment unless it is essential to save the child's life and for the best interest of the child.

- Mindful of the possibility that the adult(s) present with the child is the perpetrator, it is always important to ask a child survivor who he/she wants around and this wish should be respected.

- Reassure the child survivor that he/she will be safe, is not to blame. Also reassure such a child that he or she is not in trouble.

- Any form of stress reactions from the child survivor should be managed patiently.

- It is important to take note of persons present during interview, examination and treatment.

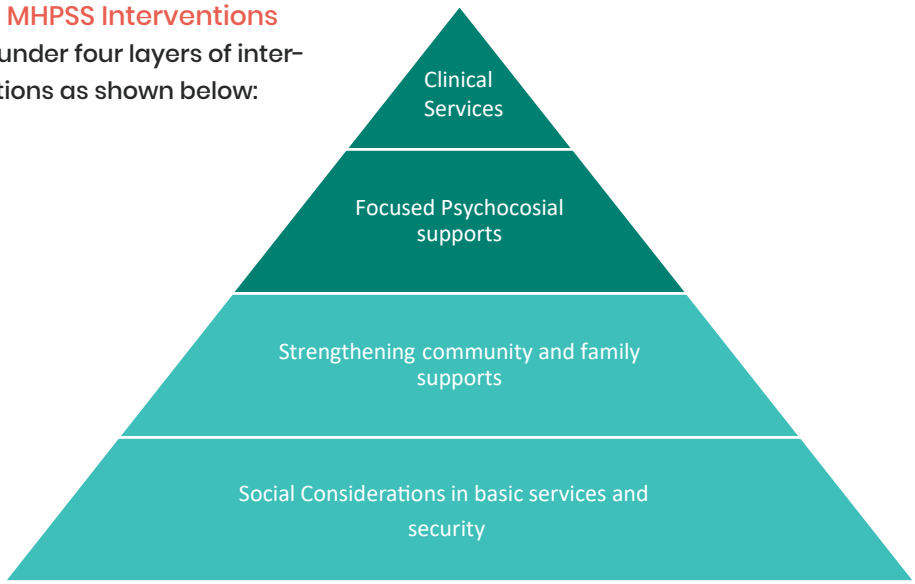
- Under no circumstance should a child survivor be restrained, forced or frightened into compliance for examination or treatment. Also, they should not be mocked, body-shamed, belittled or punished for any form of non-compliance.

6.2 Mental and Psychosocial Response

Mental health and psychosocial support (MHPSS) is the support people receive to protect and promote their mental and psychosocial wellbeing. It aims at preventing/treating mental disorder such as depression, anxiety and post-traumatic stress disorder (PTSD). Caregivers should promote a sense of safety, calming, self and community efficacy, social connectedness and hope. This response helps maintain a continuum of family and community-based care and support after a GBV incident and prevents immediate or long-term health disorder following the traumatic incident.

6.2.1 MHPSS Interventions

Fall under four layers of interventions as shown below:



Examples

Clinical, mental health care (whether by PHC staff or mental health professionals)

Basic emotional and practical support to selected individuals of families

Activating social networks
Supportive child-friendly spaces

Advocacy for good humanitarianpractice: basic services that are safe, socially appropriate and that protect dignity

6.2.1.1 First Layer: Basic Services and Security

The larger number of persons as reflected at the base of the pyramid recover their mental and psychosocial well-being when the basic safety and security is established, or when they get social materials such as food and NFIs.

6.2.1.2 Second Layer: Community and Family Support

As indicated on the second level in the pyramid, a smaller but substantial number of persons (survivors) need additional support from their families and communities in order to recover their psychosocial well-being. Support with social re-integration such as vocational training, empowerment programmes, school reintegration and literacy training, family tracing and reunifications, women's groups, youth clubs, parenting/family support, structured recreation and creative activities. These types of services can be provided by other service providers and community members. The support focuses on responding to immediate and non-complex psychosocial distress. It also aims at preventing more severe forms of distress and mental health disorder.

6.2.1.3 Third Layer - Focused, non-specialized support

This is support given to a smaller number of persons who need more focused services to regain mental and psychosocial wellness as shown in the pyramid. This is provided by psychosocial workers and trained GBV responders, child protection workers and MHPSS actors who can give psychological first aid (PFA) to survivors or provide case management. PFA responds to the emotional and psychological distress of the survivor. Response provided may include basic emotional and practical support, providing opportunities for survivors to discuss their experiences, discouraging negative coping mechanisms, providing one-to-one or group psychosocial support (PSS) sessions and encouraging participation in everyday activities. This intervention also includes provision of counseling for individuals, groups or families as well as psycho-social education about trauma and stress.

6.2.1.4 Fourth Layer - Specialized Services

There is yet another smaller percentage of persons who require more specialised care for their mental and psychosocial well-being.

These persons require professional support from trained health professionals and international medical organisations such as clinical psycholo-

gists, psychotherapists and psychiatrists. This intervention is for survivors with severe mental and emotional disorder suffered whether pre or post the GBV incident.

6.2.2. When GBV Survivor requires MHPSS Care

GBV survivors can be helped to access the basic needs contained in the first layer as well as the second layer, that is, reconnect with family and community support system. However, when it is determined that a survivor needs a higher level of mental health care, GBV case management can aid the survivor in getting access to such care. Referral to specialised mental health professionals in the fourth layer should be made when:

6.3 Security and Safety Response

Security and safety are important in responding to GBV incident because survivors, their families and the service provider may be at risk. It is therefore essential that all actors should prioritize security and safety. The relevant actor to provide safety and security when needed should be pre-identified and have clearly delineated responsibilities. In providing services to survivors, there may be occasion when survivors would need to be relocated away from their assailants to a secure and safe environment. This necessitates that Actors should identify shelter options for survivors at risk. Short-term shelters can be provided through safety networks and foster families for survivors especially girls and children. Where a child is involved, it is emphasised that the best interest of the child is the priority consideration in the provision of shelter and care.

Service providers upon receiving a case of domestic violence may work with survivors to explore options and strategies to stay with or leave family depending on safety considerations. The following considerations can help ensure the safety and security of GBV survivors:

- Find strategies that will enable survivors stay with their family when appropriate or finding a trustful family member to stay with. However, this should be done when family members are not the aggressors. Non-offending family members should be involved as caregiver in the healing process particularly when one of the parents of the child GBV survivor is the aggressor.
  NOTE: Safe houses (or orphanages) should be considered as a last option because of the various complexities involved, and where it is used, should be used as short-term intervention while longer-term solutions should be worked at.

- The survivor may be provided with a means of communication such as phone or airtime credit to enable him or her to contact case manager. However, this should be done only after a risk assessment that shows that neither the survivor nor service provider is put at risk. In the alternative, trusted persons should be involved in reaching survivor when the survivor is without a means of communication.
  Immediate alternative shelter should be provided until better and longer-term alternatives are identified.

- A survivor referred to a shelter should be monitored till safe arrival at this destination;
  NOTE: Again, this should be used when the risk associated is not enormous.

- Emergency hotline number should be provided.

- Actors should follow leads and be willing to support survivors to press criminal charges in a professional and appropriate way.

- There should be frequent follow-up where the survivor is at risk if the alternative of relocation is not possible.

  Personnel involved in GBV case management should be trained to identify GBV survivors at risk of doing harm to themselves.

- Organisations providing services (GBV and other services) should ensure that their personnel know and comply with security procedures, and code of conduct.

- In instances where there is repeated or escalated domestic violence, service providers should help survivors establish a safety plan including helping them to identify the means of decreasing triggers that lead to aggression.

- Provision of expert statements, report and testimony to courts where and when necessary.

- Service providers who are not security agents should never assume the duties of a security agent; they have no power to detain suspects.

- Survivors should be encourage reporting all cases to the police and following through with the legal process, Again, it is emphasized that in following through with this process, the survivors' consent must be obtained and also all victim-centred standards in the referral pathway to the legal process must be adhered to. Support should be provided for survivors with the view to minimize stigma and to promote individual rights.

- Participate in awareness raising activities within the communities and promote/influence behavioral change within the socio-cultural environment.

- Actors should make referrals to other service providers available including medical, psychosocial and legal aid in accordance with the expressed wishes of the survivor

6.3.1 Security Agents/Law Enforcement

Appendix 4 for a List of Security Agencies in Lagos State and their contact details.

GBV cases that constitute offences are to be investigated and prosecuted by security agents and law enforcement officers. In doing this security agents and law enforcement officers should display a high level of professionalism and adequate knowledge of the response strategy in handling GBV incidents because their response has implications for access to justice for survivors.

Some key considerations that security and law enforcement agents must work with are:

- A healthy synergy should be created and maintained between the security agencies and other service providers. By virtue of their mandate, they may also be the first point of call for GBV survivors.

- Medical treatment should be given priority before interviewing survivor especially in cases of rape and other forms of sexual assault unless otherwise is deemed necessary.

- Obtain the informed consent of the survivor before referral to other service providers.

- A GBV-desk should be designated at every police station to ensure appropriately trained officers are available to attend to GBV cases. Designating GBV-trained officials in specific police stations with Family Support Units (FSU) is inadequate.

- Every policing and security agency e.g. the Nigeria Civil Defence and Security Corps, the Neighbourhood Safety Corps should have a Gender Desk with an appropriately trained officer.

- Survivors should be interviewed in a private setting and handled with confidentiality following the necessary guiding principles.

- Officers of same gender with the survivor interview the survivor except where the survivor expresses a wish for or consents to being interviewed by an officer of another gender.

- Cases should be handled with extreme confidentiality;

- Where and when necessary, the police should visit the scene of the incident at the earliest opportunity to obtain necessary evidence and effect arrest.

- A case file should be opened and all relevant

documents be processed and sent to the Ministry of Justice or the judiciary if/when necessary;

- All effort should be put in to ensure that persons accused of GBV are apprehended and processed successfully through the criminal justice system by ensuring that a high quality of investigation and prosecution of such cases.
- In handling GBV cases, each member of the security agents team on each case should be properly briefed and involved on every stage so as to ensure continuity and justice in the eventuality of any of the team members being posted out of the station before the completion of investigation and/or prosecution,
- When survivor needs temporary protection particularly during investigation, referral to appropriate service providers should be made and the security agents should ensure that the survivor has access to social welfare, forensic and psychosocial services.
- The survivor and his/her family members should be protected when necessary from intimidation and/or further assault from perpetrator or his friends and family.
- Obtain the informed consent of the survivor. In the case of rape, it is of outmost importance that the survivor receives lifesaving medical services as a first priority.
- A case file should be opened from where all the relevant documents should be kept and processed; incidence should be documented in appropriate registry.
- Ensure proper consultation and communication with other service providers with whom survivor has been referred.

6.3.2. Capacity Building for Security Agencies /Actors on GBV Incidents

Security agents must be trained to know and understand their roles and responsibilities in handling GBV cases. This training should be part of their rehearsal exercise, scenario-based training and in-mission refresher course. Training should also move away from the theoretical base to conceptualized practical approach that meets with field challenges.

These trainings should include:

- Human rights, guiding principles for the prevention and response to GBV, women and child's rights, Code of Conduct.
- Emotional and Psychological state of GBV survivors, their reluctance in allowing security actors' interventions.
- Communication techniques particularly for children, in making them comfortable and trusting enough to disclose and talk.
- Treating survivors with dignity and compassion, not insinuating blame.
- Exposure to gender-based security threats, rather than being limited to cultivating awareness only on the prevention of sexual exploit and/or domestic abuse, particularly when used by armed groups.
- Maintaining awareness of GBV security issues in the setting, particularly those affecting children, women and girls.
- Follow-up on the wellbeing of the survivor ensuring access to social welfare, medical, forensic and psychosocial services;

6.4 Legal/Justice Response

Legal/Justice responses are services which include legal counseling, assistance, and representation for survivors both adult and children when they desire to press charges against the

perpetrator or in instances relating to personal status such as divorce, custody of children, maintenance, etc. Legal response also includes the provision of information on existing measure that can prevent further harm by the aggressor; the court procedures and justice mechanism for redress; the attendant pros and cons of legal options available; the cost implication and emotional and psychological implications of lawsuits.

Information that should be provided to survivors as soon as a report is received include:

- Information about existing measures that can prevent further harm by the alleged perpetrator;
- Information on court procedures, and any issues pertaining to national justice mechanisms
- Information on available support in the event that legal proceedings are initiated;
- Information on the pros and cons of all existing legal options which include highlighting the inadequacy of any traditional justice solutions that do not meet international legal standards;
- Options for obtaining legal representation before the court if the survivor wishes to take legal redress;
- The survivors should be informed of any cost implication from the beginning;
- Child survivors should be consulted on the option for legal justice and made aware of the available services and their limitations. The child's needs, wishes and feelings are taken into consideration and every effort is made to enable the child to express himself/herself and to take part in the decision-making process;
- The child is accompanied to all court proceedings, including pre-trial sessions, trial and sentencing and is provided with legal representation before the court.

Provision of the legal/justice-related services are multi-dimensional and are offered by different agencies of the justice administration process. These multi-dimensional services and how each group of actor should respond are described below:

6.4.1 Judicial Procedure

Providing legal assistance to survivors often involves engaging with various sectors within the justice system. Depending on survivor's first point of contact. Participants relevant in the legal/justice response include the security and law enforcement agents such the Nigeria Police, the Armed Forces (in some instances), National Security and Civil Defence Corps (NSCDC), NANTIP, the Ministry of Justice and its agencies such as OPD; Directorate of the Public Prosecutor (DPP, the courts – High Court (including the general Criminal Division and the special divisions such as the Sexual Offences Court and the Family Divisions, the Magistrates' Court and the Customary Court. The court may issue a Protection Order under the Protection Against Domestic Violence Law of Lagos State (2007) for a determined duration for protection purposes if necessary or when requested by a survivor or anyone representing survivor. If the Protection Order is violated, the offender may be imprisoned.

STAGES	SERVICES
Preventive measures to prevent GBV including enlightenment and campaigns	Carry out awareness-raising activities about services, laws, policies and procedures
Initial Contact	A positive initial contact experience with the justice system, respectful of the survivor's right, is important for survivors of violence
Investigation	Assessment and investigation should begin promptly and be conducted professionally. Survivor's safety, security and dignity should be considered and maintained
Pre-trial/Hearing Processes	There is the need to carry out non-biased criminal, civil, family and administrative pre-trial/hearing processes that is sensitive to the specific needs of the survivor and which guarantee their rights to justice.
Trial/Hearing Processes	There should be measures in place to prevent further hardship and trauma that may result from attending the trial. Ensure that trial processes maximize the survivor's cooperation, promote her capacity to exert agency during the trial state while ensuring that in criminal mater, the burden of seeking justice is on the State.
Perpetrator Accountability and Reparation	Appropriate sanctions to hold perpetrators accountable for their actions and providing for just and effective remedies to the survivors for the harm or loss they have suffered.
Post-Trial Process	Measure to support healing and rehabilitation

6.4.1.1 Judicial Institutions/Courts

- Judicial officers should ensure that cases of GBV are prioritised for hearing. This will safeguard against witness fatigue. Specialised hearing and the prioritization of GBV cases should be available for sexual violence offence in the High courts should be extended to all offences and available at the Magistrate and Customary courts.
- Customary courts judges should be trained on issues of GBV and encouraged to adopt this SOP to guide its processes.
- Safety and security measures should be put in place during the trial GBV cases particularly rape and sexual assault and when it involves children.
- The court should sit in private (that is, out of the view of the public) especially when the case involves a minor.
- Protect the rights of perpetrators/defendant by advising the perpetrator/defendant of their rights and providing legal aid where necessary to give a fair trial.
- When children are involved, social worker should be introduced particularly when such children are expected to deliver official statement or give evidence to court.
- To ensure that GBV child survivor are speedily and safely re-housed in a temporary accommodation, there should be dedicated magistrates to issue care order; and they should be accessible all-round the day, weekend inclusive.

6.4.1.2. Prosecutor/Defence

- Prosecutor should do an evaluation to determine whether or not to prosecute and whether there is sufficient evidence to support the prosecution
- When case file is submitted by the relevant security agent, criminal lawsuits should be initiated
- Free or low-cost legal aid should be provided where necessary, exploring services of the Office of the Public Defender (OPD) and Citizens' Mediation Centre.
- Prosecutor should coordinate with other Actors including police or appropriate security agent, health professionals, psychosocial service provider to promote prompt investigation of the crime and support for the survivor.
- Office of the DPP should fast track its response in providing advice on GBV cases to ensure speedy dispensation of justice before damage to/loss of evidence and witness fatigue.
- Survivor or parents/guardian in case of minor should be kept informed about the case.
- Prepare the survivor for trial when he/she will be giving evidence in court.
- Give necessary information to survivor on upcoming hearing dates.
- Defence counsel should respect the rights of the survivor.
- Defence counsel should clearly and honestly inform the defendant of the procedures, limitations, pros and cons of all possible legal options.

6.4.1.3. Ministry of Justice

- Provide adequate training for its staff on GBV procedures.
- Personnel should adhere to the guiding principles in handling GBV cases.
- Liaise with all the Actors to ensure effective and ethical investigation of all GBV cases.
- Provide resources for the GBV trial process.
- Coordinate with other Government Ministries/Agencies involved in GBV and the Judiciary to ensure an integrated and effective response.
- Inform survivors of other available legal options particularly civil options for compensation.
- Afford the survivor the right to initiate a civil proceeding in regard same incidence for different reasons such as divorce, child custody, compensation, injunctions etc.

6.4.2 Roles and Responsibilities of Ministries and Governmental Agencies

- Create and strengthen network and collaboration among Actors.
- Provide training and provision of supportive supervision for health and psychosocial workers.
- In collaboration with other actors, provide education and enlightenment to the public on GBV prevention, responses and available service providers.
- Ensure information sharing and coordination.
- Mobilize resources and raise funds to address health and psychosocial needs of GBV survivors.
- Conduct regular assessment on quality of care for GBV survivors and lead situational analysis assessments.
- Provide legal support for other Actors.

- Provide accessible healthcare to vulnerable members of the society particularly women and children.
- Create and maintain a highly confidential data base system on health and psychosocial interventions.
- Liaise and collaborate with other Actors including security services.
- Develop capacity of health and psychosocial responders.
- Ensure community participation in GBV prevention and response activities.
- Social Welfare Department should ensure all-round service provision, including weekend services.
- Ministry of Education in collaboration with the Social Welfare Department should establish a school social work desk in every school to offer.

6.4.3 Mediation and traditional justice mechanisms

Mediation is a process that is frequently used in informal justice and under customary law to solve disputes between community members, families and family members. Cases of interpersonal violence (IPV) and domestic violence are commonly brought forward for 'settlement' by traditional or religious leaders, as such is considered a private family matter.

However, in general, mediation is not recommended as a response to IPV because of the safety risks that it poses for the survivor. Survivors seeking help from organizations responding to GBV may want their cases to be handled through mediation because they want the violence to stop and may perceive mediation as a way to facilitate this. In some cases, they even request that social workers carry out the mediation. It is important that organizations have clear guidelines on how to respond to these requests in a way that is survivor-centered.

Mediation is not a recommended response for most GBV cases because rather than stop the violence from happening in the long term, it has the potential to escalate violence, causing more harm to the survivor. This is because:

- The mediation process itself often maintains and contributes to the abuser's ongoing power and control over a survivor.
- The process of mediation presumes that both parties can speak freely, confidently and safely but all too often, because social norms do not enable women to speak freely or have their views considered as having equal weight or worth, it is unlikely that a survivor is going to feel that she can speak freely and without fear of consequences.
- It is also possible that just making a referral to mediation can cause harm to the survivor; as the abuser may get angry that survivor has told others about the violence.
- Mediation rarely results in an end to the abuser's violence, and can actually lead to an increase in violence.
- There is a high risk of survivor blaming within the mediation process. The perpetrator, who is used to blaming the survivor, will have a platform to articulate his position, and given the cultural and social norms in place, and the fact the survivor may feel intimidated or scared to answer back, the perpetrator may sound convincing. The survivor may be asked to change his/her behavior as a condition for violence reduction.

Nonetheless, it is important to acknowledge that any survivors have recourse to traditional justice mechanisms to get justice for GBV. They may do this voluntarily but at some other times, involuntarily as a result of direct and indirect pressure. It is therefore important that conscious, careful, and respectful attention should be given to the actions of such mechanisms in responding to reports of GBV. These may require interventions such as

- Actively engaging members of traditional justice systems in discussions and training workshops about human rights, women and children's rights; and survival centered approach in assisting the members to analyze the system from a human rights perspective and, when needed, working towards introducing changes to improve the standards.
- Supporting the meaningful participation of women in such systems
- In collaboration with the formal justice system, determine if traditional or alternative forms of dispute resolution meet national and international standards of protecting the rights of women and girls, and offer sufficient protections to the women and girls involved in these proceedings.

6.5. Roles and Responsibilities of non-government GBV Service Providers within this SOPs

As there are several organisations with different focal concerns around which they work, there are different roles and responsibilities identifiable for them. The roles and responsibilities of an NGO providing GBV services would depend on its focus although some tasks and responsibilities may overlap. Below are recommended responsibilities for each focus group:

6.5.1. The Health Group:

- Ask detailed questions about what happened during the incident
- Ask detailed questions about injuries
- Conduct a medical examination of survivor
- Document injuries and collect forensic evidence
- Provide emergency contraception, and treatment for injuries and STIs
- Provide a medical certificate
- Provide testimony in court
- Provide information about possible health consequences of sexual violence or other violence

6.5.2. The Psychosocial Support Group

- Where trained professionals are available, conduct individual counselling or group counselling and if the survivor appears unusually distressed or is unable to function in daily life, conduct a mental health assessment of the survivor.
- Provide skill-training for survivors
- Provide material support to survivors (e.g. clothes, food, shelter)
- Facilitate access to income-generating activities for survivors to empower them
- Ensure that available mental health services are equipped to deal with disorders resulting from sexual violence
- Work with the community to reduce stigma and discrimination against survivors of sexual violence and to mobilize community support and protection against further harm for survivors

6.5.3. Legal Services Provision Group

- Enhance and promote the welfare and rights of vulnerable such as children, women and persons with disabilities
- Provision of legal aid through the various pro bono activities of NBA, FIDA, AWLA and other groups within the legal profession. Legal aid should be extended to lower courts such as magistrate and customary courts.
- Promote sexual and reproductive health education and rights
- Fight against child labour, human trafficking, etc.
- Promote social and/or political change on a broad scale or very locally.

CHAPTER 7:
CASE MANAGEMENT



Various harmful physical, emotional social consequences arise from GBV incidence which make survivors need multiple services, some which are complex. Hence, survivors may need to access services from a several range of service providers, groups and organisations. Also, the needs of each GBV survivor vary and the effect of the incident differs from one survivor to the other. The consequences of a GBV incident may have a lifelong effect on some survivors, their relationships, wellbeing, communal and societal interaction. Such survivors would need longer, and more lasting care through case management

Case management is a structured method for providing help to GBV survivors. Through case management, the survivor is informed of all options available to them; and issues or problems facing a survivor are identified and followed up in a coordinated way. Case management aims at achieving survivor's wellness and autonomy through advocacy, communication, education identification of service resources and service facilitation..

It also helps to reactivate the coping mechanism of survivors and aid healing. In the process of case management, the survivor is empowered with information and awareness of the several choices available to them as they seek to deal with the problems confronting them and assisted to make informed decisions about what to do about those problems.

A case management approach is useful for survivors with complex and multiple needs who seek access to services from a range of service providers, organizations and groups. Case management serves as a means for achieving survivor wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The goal of case management is to empower the survivor and, where appropriate their families or caregiver by giving her/him increased awareness of choices they have in dealing with the problem, and assisting her/him to make informed decisions about what to do about the problem. Case management ensures that the survivor is involved in all aspects of the planning and service delivery.

In the case management approach, service providers must adhere to the following basic guiding principles in handling cases:

- Ensure the survivor is the primary actor in case management;
- The survivor should be empowered and involved in all aspects of planning and service

delivery. The types and limit of service to be provided should be discussed at the initial contact with the survivor so as not to give a false hope to the survivor.

- The wishes, rights, dignity and capacity of the survivor must be respected always.
- Conducive environment should be created to enable the survivor to freely interact and unburden his/her mind.
- A trust relationship should be built between the survivor and the case management service provider. This helps to create a supportive environment in which the survivor can begin to heal.
- There should be no discrimination of whatever kind; every survivor should be treated with dignity irrespective of religion, sex, race, ethnicity, family background and circumstances of the incident.
- Survivors should be provided with information on available services which will enable them to make informed choices. Providing information to the survivor to allow him/her make informed choices about services requested;
- Service providers must be empathetic and provide survivors with emotional support.
- Possible options for civil justice should be brought to the attention of survivors. The Citizen's Mediation Centre (CMC) desk in every LGA should be service providers in this regard.



7.1. Steps in Case Management

STEPS	TASK
STEP ONE: Introduction and Engagement	• Greet and Comfort the survivor • Build trust and rapport • Assess immediate safety • Explain confidentiality and its limits • Obtain permission (informed consent) to engage the person in services
STEP TWO: Assessment	• Understand the survivor's situation, problems and identify immediate needs •Provide immediate emotional and material support •Give information •Determine whether the survivor wants further case management services
STEP THREE: Case Action Planning	•Develop a case plan based on assessment with survivor •Obtain consent for making referrals (if necessary). •Document the plan
STEP FOUR: Implementing the Case Action Plan	• Assist and advocate for survivors to obtain quality services • Provide direct support (if relevant). • Lead case coordination
STEP FIVE: Case Follow-Up	• Follow up on the case and monitor progress • Re-assess safety and other key need. • Implement a revised action plan (if needed).
STEP SIX: Case Closure	• Assess and plan for case closure
STEP SEVEN: Service Evaluation	•Evaluate the efficiency/effectiveness of services provided

7.2 Options in Case Management

In case management, service may be extended, that is, long term assistance for specific or special groups of survivors depending on the severity of the incidence, the nature of the survivor and how the survivor is able to respond to services provided. Services can come in form of cash support, integration into several community groups. Below are recommended options available:

1. Education
2. Financial support
3. Skill building and Vocation

7.2.1. Education

In case management process, education plays a vital role when it comes to child survivors. Schools often provide a safe space for children to lean and develop and helps in integration of survivor into the community and prevention of GBV. Survivors can be enrolled in educational institutions as a form of response in case management. Adult survivors may also benefit from adult education as a means of healing and re-integration into the community.

7.2.2. Financial Support

For a survivor-centered care, cash is a vital factor in responding and/or preventing GBV. Financial support can be lifesaving because cash can help support the recovery of survivors and further ensure safety and security. For example, money may be needed to meet the cost of new accommodation, food, clothing and some medical needs. At other times, survivors may not be able to take up the financial responsibility for some types of services e.g. legal and medical care. In such cases, cash support facilitates access to services. Before financial support is given to the survivor, a case management service provider must ensure:

- That it is appropriate and meets the need of the survivor
- That it does not further expose the survivor to danger or harm.
- That it is monitored closely for the survivor's needs through the GBV case management process.

7.2.3. Skill building and Vocation

In some instances, survivor's healing and reintegration can only be fully achieved through skills acquisition for the survivor. When GBV occurred as a result of the vulnerability of the survivor based on non-existing means of livelihood, the survivor needs to acquire livelihood skills. Skill acquisition can reduce and/or eliminate vulnerability to abuse. Skill acquisition promotes independence of the survivor from continual dependency on an aggressor or the situation or environment which facilitated the GBV. Case managers should do a proper assessment to determine whether the survivor needs to acquire further skill and vocation as a form of response.

7.3. Case Management with Women and Adolescent Girls

The World Health Organization has stated that one in every three women will experience either physical or/and sexual violence by a partner or non-partner in their life-time.
According to UNWomen (2011), Facts and Figures on Violence Against Women, among 15 to 44-year old, violence causes more death and disability than cancer, malaria, traffic accidents and war combined.

There is widespread discrimination and gender inequality which expose women and adolescent girls to multiple forms of violence throughout their lives. Almost half of sexual violence against women are towards girls aged 15 and below. Women also are the most vulnerable in times of crisis, war, natural disasters, conflict and humanitarian emergencies. Risk associated with women include:

- Women and girls are at risk of sexual assault and rape during emergencies, especially if food, water or fuel source are far from settlements or located in unsafe areas.

- Women and girls are at risk of sexual exploitation – including the exchange of sex for essential goods and services, trafficking and sexual slavery.
- Women and girls suffer sexual violence in the hands of members of law enforcement agencies, military and other armed groups.
- Violence by intimate partners and male members can escalate during emergencies. This tends to increase as crises worsen and men lose their jobs and status – particularly in communities with traditional gender roles and where family violence is normalized.
- Girls are vulnerable to forced and early marriage during emergency situations.

7.3.1. Sexual violence

Survivors of Sexual violence faces many barriers to accessing care and support mainly because they:

- Feel shame and embarrassment.
- Blame themselves or fear blame by others.
- Want to protect perpetrator.
- Think what happened is normal.
- Fear from perpetrator or his family
- Know there is a possibility that the response from family, community and authorities could be so negative that they could be blamed, stigmatized, ostracized, punished and in extreme cases, even killed.
- Fear they will not be believed or will not be treated well
- Lack proof that the incidence occurred
- Do not think that what happened is a crime or it is serious enough to report to the police
- Do not know how to report.
- Doubt that the justice system will provide redress.

7.3.2. Early Marriage

Case Management of early marriage depends on whether there is a risk of imminent marriage or there is an early marriage already in existence. Below are recommended guidelines for both:

FOR IMMINENT RISK CASES	FOR GIRLS WHO ARE ALREADY MARRIED
• Get consent to work with the girl • Assess how she feels about marriage. • Provide information to the girl about the consequences. • Identify with her a supportive family member or other trusted adult. • With the girls consent, engage the supportive family member or other trusted adult. • If person identified is parent/caregiver: - Discuss pros and cons of early marriage. - Provide information on the consequence of early marriage. • If person identified is not parent/caregiver: - If it is safe, to do so, support the person to have conversation with the decision maker in the family (with the girl's consent). • If Marriage is likely to go forward, focus on risk reduction. - Assess the girl's concern and questions, potential risks related to her safety and health. - Carry out safety planning. - Provide information about service and make referrals	• Get consent working with the girl. • Assess her needs. • Provide information about the consequences of early marriage. • Provide information about services available and make referral. • Carry out safety plans. - Help her identify a supportive person in her life. - Help her identify positive coping strategies. - With her consent engage (or continue to engage) a supportive adult.

7.3.4. Working on Intimate Partners Violence

Working on this category is complex because of the continuing exposure the survivor had to violence and how it impacts her physical and psychosocial safety and wellness. Survivors of Intimate Partners Violence situation are at continuous risk if harm. Therefore:

- Identify the circumstances in which the survivor is most in dangers.
- Access risk of escalated violence. Determine if the survivor is at risk of life threatening physical harm.

- Plan for safety.
- Never assume or communicate that leaving is going to be better for the survivor. Do not advise her to leave.
- Focus on ways they can reduce their risk of physical violence and help them to think through what they would do if they had to leave temporarily or permanently.
- Explore potential safety strategies. The following questions can help to develop safety plan with survivor:

  i. Identify her existing responses – what do you do when you are in danger, discuss how this is working

  ii. Identify her existing resources (people, money, material).

- Discuss what would happen if she needed to/decides to leave –who else will be in danger, her children etc.

7.4. Case Conference

Persons using the case management approach serve as link between the survivor and service providers who advocates for timely and quality care for the survivor. However, for this to be effective there is need for regular communication and follow-ups with the other service providers. This requires case conferencing, which is a planned and structured meeting convened by the caseworker in which a particular case is discussed with other service providers. These are essential for case conferencing:

- Survivor must consent to case conferencing; he/she must also consent to information sharing during the case conferencing.
- Case conferencing is done on ad hoc basis which differ from the usual ongoing service coordination or case reviewing.
- Service providers are to participate in case conferencing only on invitation.
- The guiding principles of confidentiality and dignity should be maintained.
- The aim of case conferencing is to:

  a. Review activities, progress and barriers to goals

  b. Map out roles and responsibilities

  c. Resolve conflicts and strategies solutions

  d. Adjust current actions and plans

7.5. Case Follow up and Closure

7.5.1. Case Follow-Up

Following up cases is an integral part of case management. When cases are being followed up, case worker should:

- Monitor the case
- Make sure the survivor is safe and getting the help they need, and identify and overcome barriers or problems.
- Identify new challenges/problems and solutions.

In following up, case worker will:

i. Meet with or contact the survivor as agreed

ii. Re-assess safety

iii. Reassess Psychosocial state and functioning

iv. Review the case action plan with the survivor

v. Revise the case action plan

vi. Implement revised case action plan

7.5.2. Case Closure

The duration for the management of each case vary depending on several factors including the survivor's need and the context in which the case worker is working.
Closure should be built in from the beginning of the programme and the closure should do no harm to the beneficiaries particularly the GBV survivor. Cases can be closed:

- When the survivor's needs have been met and/or the support systems (whether pre-existing or new) are functioning
- When the survivor wants the case to be closed, e.g. when the survivor leaves the area or is relocated to another place, or when you have not been able to reach the person for a minimum of 30 days.

When the decision is reached that the case should be closed then the case worker should:

Document when the case is closed and the specific reasons for doing so – complete a case closure form, review all the forms in the survivor's file and make sure they are complete.

Store safely, the closed file by moving the closed case to another cabinet where closed files are kept. It is important to note that you should not include the consent form in the closed file.

Administer a client feedback survey, if the survivor is reachable.

7.5.3. Closure due to Emergencies

When cases need to be closed based on an emergency such as funding restrictions, lack of competent personnel, security issues, operational restrictions, etc. the following procedure is recommended:

1 A replacement organisation should be sought and case referred to the organisation.

2 Ensure that ethical and secure management of data.

3 Consult with both staff and beneficiaries about the closure

4 Intake of cases should cease.

5 Communicate the closure to all stakeholders.

CHAPTER 8:
RESPONSIBILITY FOR PREVENTION



GBV responses also include preventive measures, consequently, prevention and response are inter-related. Preventing GBV means identifying and removing those factors that make certain members of the local community vulnerable to violence and designing activities that improve their protection. To prevent gender-based violence, GBV causes and contributing factors in a given context should be identified, understood, and addressed. However, this cannot be done without engaging and mobilizing the community to become aware of gender roles and stereotypes, men's power over women, and how the community's silence about this power imbalance perpetuates violence against women and girls and GBV. In order to achieve this, GBV actors should at the outset:

- Map out local representatives from key institutions (e.g., health care providers, religious leaders, teachers, lawyers, law enforcement, etc.).
- Identify local resources and engage people from the community who can support the overall implementation of preventions activities;
- Select and provide coaching to focal points in collaboration with the community and follow protection criteria to help plan, design, and implement activities;

Preventive activities should be aimed at potential victims, and potential perpetrators and those that will assist them. Preventive activities that will impact communities, staff of government and non-NGOs should be embarked on. These activities, which may include campaigns, enlightenment programmes, mass media jingles, and several awareness-raising initiatives should be used in response activities and be targeted at the general public. Various structures and institutions in the community have a great role to play in creating, implementing and evaluating strategies to prevent GBV.

Actors need to collaborate and work with the various sectors within the community to identify volunteers who will support and run GBV preventive/response activities. Groups within the community that act as GBV preventive responders and with whom actors can collaborate for prevention include:

- Educational institutions
- Religious organisations/Leadership
- Community groups
- Women's Groups
- Men's Groups
- Youth Groups
- Children's Groups/Clubs

8.1. Educational Institutions

Although persons working in this sector can be trained on GBV prevention and response, which will be of immense assistance, the school presents a widespread platform for which GBV occur.

It is important that schools should adopt a Code of Conduct that clearly prohibits GBV and all forms of sexual abuse and exploitation. Schools also present the opportunity for child survivors to be re-integrated into the system. Actors can collaborate with schools to offer various activities for enlightenment of both students, families and staff on GBV

8.2. Community/Religious Organizations and their Leadership

The various leaders of thoughts in the religious organisations are great influencers and role models for a number of their followers, they play enormous role in directing the thought and action of individuals within the community and they can become active partner in GBV prevention. They should be encouraged to make pronouncements on human rights and the evils of violence. Also, they are often first point contact for GBV survivors, they should be educated and informed on importance of referral.

8.3. Community Groups

For success to be achieved in GBV prevention response, the participation of the community is very vital. There must be the community buy-in which must reflect in the cultural attitudes towards children and women (in particular). Community participation should not be limited to specific groups; several groups within the community should be integrated including boys and men's groups. The community groups can be taught the basic human right principles particularly as regards children and women.

8.4. Women's Groups

Women groups are very viable in mobilizing prevention and response to GBV. The several groups within the community should be trained in GBV prevention and response. They can also be provided targeted leadership training to support their meaningful participation in public decision-making processes including traditional justice systems to uphold women's right.

8.5. Men's Groups

Men's groups are important tools in GBV prevention and response as they assist in promoting positive non-violent masculine norms and behaviors. They can recreate a new socio-cultural order that is inclusive and gives acknowledgment to women, children and their rights. Therefore, this group is an essential component for GBV prevention and response; they should be sufficiently involved in all GBV activities. Men groups should be engaged in activities that will promote gender equality, prevent domestic violence; sexual violence; and other forms of harmful traditional practices. Further, men groups should be involved in programmes that will effect individual attitudinal changes in the short term resulting in an incremental societal change in the longer term. Men groups should also be made to know and understand that men and boys can be victim/survivors of GBV; therefore, male survivors should be identified. Activities and programme of Men's group should be complementary to women and other groups not competitive.

8.6. Youth Groups

This age range being vibrant and energetic can be of immense help awareness-creating activities on GBV prevention and response.

8.7. Children's Groups/Clubs

Children's groups/clubs present a very viable platform for reaching out to children; to teach them on abuse and to build their confidence for reporting. Children should be engaged in awareness-raising activities that will teach children on how and where to report abuse. It may further assist in helping to make referral mechanism child friendly.

CHAPTER 9:
COORDINATION AMONGST ACTORS AND AGENCIES



The sole focus of coordination amongst GBV actors and stakeholders is partnering to complement one another. Competition and blame trading should be avoided. Personnel and staff of all service providers and actors should speak to one another in friendly and operate in professional and team-like manner.

9.1. Coordination amongst Security Agencies

- The Police are statutorily empowered to prosecute GBV. However, some other agencies may also share this power. For example, when GBV relates with human trafficking, NAPTIP has the statutory power. In cases where the statutory mandate is shared, it is imperative that there is coordination between the relevant agencies e.g. NAPTIP and the Police for effective and speedy investigation and prosecution of cases.

- When the receiving organisation of the GBV survivor is law enforcement agency but one without prosecutorial powers such as the Nigerian Security and Civil Defence Corps (NSCDC) and the Lagos State Neighbourhood and Safety Corp, or any other security outfit created by law, all GBV guidelines in this SOP must be followed. Thereafter, the case should be referred to the Police to undertake the prosecution; or referred to other appropriate Ministries. (see Appendix V).

- NOTE: Referral, even at this stage, should be with the consent of the survivor.

- A receiving security agency should a follow-up the referral till the appropriate conclusion of the matter.

9.2. Coordination amongst Government Agencies and Non-Governmental Organisations

Government Agencies which include all Ministries and governmental agencies (see Appendix V), and NGOs are GBV stakeholders and service providers. In working together, the following should be reinforced:Government Agencies which include all Ministries and governmental agencies (see Appendix V), and NGOs are GBV stakeholders and service providers. In working together, the following should be reinforced:

- The Referral Pathway stated in this SOPs should be adhered to, in order to achieve appropriate result
- The Social Welfare Units in Lagos State should create and maintain an accessible and functional hotline, open to all Actors for referral at any time including weekends and public holidays.
- Actors, and service providers should avoid building service provisions and responses around individuals, rather it should be well structured and institutional.
- Participating organisations should demonstrate their commitment to the SOP

.

CHAPTER 10:

RESPONSIBILITIES OF CASEWORKERS AND AGENCIES FOR STAFF CARE

Persons involved in the GBV services are often exposed to highly stressful situations and the risk of vicarious or secondary trauma. If there is inadequate support or supervision, caseworkers become over-whelmed and begin to feel hopeless and helpless since they have been exposed to various traumas from survivors' stories and experiences. Therefore, organisations need to make explicit commitment to the staff wellbeing and implement specific strategies for promoting it.



Each organisation should develop its own strategy and plans for meeting these challenges based on structure and funding. The following are however recommended:

- Staff should be encouraged to prevent stress from becoming overwhelming by practicing self-care.
- Create a supportive climate – regular check on the well-being of staff, create an environment where staff feel comfortable sharing information and concerns with you.
- Establish routines – including for supervision and team meetings
- Regularly demonstrate appreciation for staff, this can be as simple as communicating gratitude or praise for something they did or arranging to have refreshments at meetings to something more elaborate such as "staff of the month award".
- Manage information – Routinely share information and create an environment of transparency.
- Monitor the health and well-being of staff.
- Monitor stress levels – Support staff to identify and monitor stressors in their lives and to develop self-care plans.
- Provide opportunities for exercise, recreations and access to the outdoors
- Organise "staff care" days that allow staff to come together to do something fun or relaxing.
- Encourage staff to identify a 'self-care buddy' –another staff person with whom they connect on a regular basis to discuss how they are and what support they need from each other.
- Create opportunities for staff to share experiences and stressor.
- Connect staff to psychosocial support if available in the context, connect staff to mental health professionals on regular basis.

10.1. Quality of a Case Worker

For an effective GBV response and case management, a positive relationship is necessary. The qualities of warmth, empathy, acceptance, respect and genuineness exhibited by the personnel of Service providers go a long way in determining the success and seamless operation of GBV response and case management. It is important that caseworkers exhibit these qualities to achieve a trust relationship with GBV survivors. Therefore, a case worker should work at exhibiting these qualities in handling GBV survivors:

- Respect - there should be an unconditional positive regard for the survivor, regardless of class, background or social strata in which the survivor comes from.
- Non-judgmental: Workers should be kind, accepting and accommodating.

CHAPTER 11:
INFORMATION DISSEMINATION TO STAKEHOLDERS ABOUT GBV SOPs

This SOP is valuable only to the extent that stakeholders and actors working around GBV are aware of it and commit to adhering to the standards it stipulates. Information about it should be widely disseminated to all GBV and non-GBV service providers as well as the community. The content of this SOP stipulating guidance for service providers should be communicated to all relevant groups to inform them of procedures relevant to accessing service and ways and best standards related to the carrying out of their responsibilities.

While actors – individuals and organisations working to provide GBV services and non-specialist services should each have the SOP to guide their work, it is also recommended that community members be widely informed about the existence of the SOP and its contents as this will help in enhancing the quality of service demand and service delivery.

Target Groups includes:

- Women's networks
- Teachers
- Religious leaders
- Service Providers
- Humanitarian/Human Rights actors

Information should be circulated within the community to inform the community members about the services available and standards relating to service delivery to survivors and the larger community. Information can be disseminated through:

- Posters
- Referral pathways pamphlets
- Hotlines
- Radio Jingles
- Digital/Online information dissemination
- Social Media
- Awareness creating activities
- Television Adverts

Information dissemination to the community should be guided by the following:

- Develop a dissemination plan with timeline and specific responsibilities;
- Information to communities about existing services;
- Messages should focus on safe and confidential access to assistance for GBV survivors.
- Ensure a coordinated approach and consistent messages;
- Ensure that the development of messages is focused on safe and confidential access to assistance for GBV survivors;
- Ensure that information is provided on emergency medical responses and other services
- Provide messages that are culturally acceptable and in a format that protect individuals accessing these services from risk of harm.
- Ensure that all messages are also available in the local language

CHAPTER 12:

MONITORING AND EVALUATION OF SERVICE QUALITY



It is important that services provided should be adequately monitored and proper evaluation carried out periodically for improving standard of care and service provision. This is an ethical obligation, but it is often also a requirement for receiving external funding as it helps to ensure accountability and quality assurance.

12.1. Means for monitoring of quality of service provision and case management

a Client feedback surveys

b Case file audits

c Ongoing supervision of caseworkers

12.1.1. Client Feedback surveys

This is used to assess the survivors experience on services being provided by service providers. Client Feedback Surveys:

- Help service providers/case managers to identify what is being done well and areas for improvement.
- Assist service providers in identifying challenges in the service provision process.

Client surveys should only be voluntary and survivors should participate in client surveys only with free and full consent.

Client feedback survey instruments/forms should be given at the end of session or at the closing of the case. This may, however, be inappropriate when referrals are made after first contact.

When case management is on for a longer time, feedbacks can be used frequently (e.g. monthly or quarterly).

The following process is recommended for administering clients' feedback survey to survivors:

- The purpose of the survey should be explained to survivor, i.e. to improve the services of the organisation.
- Information should remain anonymous and survivors are to be so informed

- A person other than the case worker should administer the survey.
- Due consideration should be given to survivors with disabilities.
- Before choosing to administer feedback survey, organisations should have proper resources to administer the survey in an anonymous way and to analyse the information from them.

12.1.2. Case File Audits

When an organisation has a good case documentation system, reviewing of case files on regular basis can help improve the overall service being provided. The following should be noted in the use of Case File Audit:

- Case file review should never take the place of in-person supervision.
- Case file review should be complemented with other supervision models.
- When case files are being reviewed, you should look out for the following.
  - Consent forms
  - Assessment forms
  - Case Planning forms
  - Case notes
  - Case Closure Form

12.1.3. Ongoing Supervision of Caseworkers

Continued staff capacity development is needed to ensure quality service delivery. It is therefore necessary in GBV case management and service provision that all organisations providing GBV services have at least one case supervisor responsible for ensuring that staff are trained and prepared for case management. Such a person can also play a monitoring role with respect to case workers. Case supervisors should be persons with several years and direct experience of working on GBV cases. Supervision can be provided through one-on-one support, in-groups, through on-the-job- observation and coaching and in regular team meetings.

12.1.4. One-on-One Supervision

- Should be regular and consistent
- Collaborative: Case supervisors should encourage case managers to attend meetings with clearly laid out agenda, identifying the cases they want to discuss, asking specific questions they have or topical areas for technical support.
- These sessions should be used to support caseworkers' learning and professional development.
- Case supervisors should ensure that supervision meetings feel like a safe space for caseworkers without fear of being judged; where case workers can receive constructive feedback and not criticism.
- The meeting should be a good model for the promotion of good case management practice in terms of communication, respect, dignity, empathy, etc.

12.2. Structuring Supervision Conversation

The following should be followed when discussing a new case with a case worker:

- Understand background of the case – who is the survivor; what happened; who is the perpetrator; how was the case reported.
- Understand immediate need identified - safety, medical and health, psychosocial needs.
- Understand how case worker did case planning – safety plans, referrals, identification of immediate risks e.g. suicidal tendencies.
- Support the caseworker with follow-up.
- Close the supervision session.

12.3. Peer Supervision Sessions

This is a forum where staff within the organisation meet to discuss about their work. Staff meet to reflect on the work they do, draw lessons from one another's experiences as they share information about successes and challenges. This type of supervision session affords valuable feedback and enables strategizing.

- Duration and frequency should depend on each organisation and the severity, urgency and number of cases being managed.

- Irrespective of the above, there should be regularity, and in this regard, it is best to draw up periodic meetings schedule.

- Agenda should be prepared ahead of meeting and circulated prior to meetings to allow case workers enough time to review materials and come prepared for learning and discussion.

12.4. Accountability

Accountability is important amongst GBV stakeholders and actors. The use of technology should be employed. A central website should be created wherein cases can be monitored to ascertain the case progression after referral. Where the use of interactive platforms such as WhatsApp is cheaper and more accessible, these should be used with the caveat that there must be strict adherence to the guidelines that protect survivors and information about them as elaborated in other parts of this SOP.

CHAPTER 13:

DOCUMENTATION, INFORMATION MANAGEMENT AND DATA SECURITY



13.1. Documentation

A very crucial part of GBV case management practice is documentation. Documentation is the process of recording information collected in respect of a case and storage of information collected. Documentation is used to keep track of the discussions with the survivor, steps agreed with the survivor to address his/her needs. Given the duty of confidentiality and also the need to ensure that all needed information on a case is available and easily accessible for use when needed, it is necessary that the process of documentation and data storage be efficient, confidential, safe, secured and in line with international best practices.

Several forms and documents are likely to be used in service provision and case management. These may include:

- Consent forms
- Case Plan Forms
- A written Safety Plan
- Case Notes
- Referral Form
- A Case Follow-up Form
- Case Closure Form

In documentation,

- Each survivor should have a separate case containing all relevant case management forms.
- A code should be assigned to each form used by an organisation.
- Names should never be written on the front of the case files as well as photos or pictures in the case files.
- A separate case file should be created which will contain through special coding survivors' names. This file should be stored in a different location or stored electronically and should only be accessed through protected passwords.
- Survivors should have access to read and review the information recorded about them at any time.

13.2. GBV Information Management System

A Lagos State GBV Information Management System (GBVIMS) is needed and should be put in place as a robust system for collecting, storing and sharing key information on GBV incidents. It is needed to harmonize data collection on GBV, to provide a simple system for GBV project managers to collect, store and analyse their data, and to enable the safe and ethical sharing of reported GBV incident data. The GBVIMS will assist service providers to better understand the GBV cases being reported, and to enable actors to share data internally across project sites and externally with other agencies for broader trends analysis and improved GBV coordination.

13.3 Data Security

Information collected from GBV survivors are often extremely sensitive and should be treated

with confidentiality. It is therefore important that such data be secured using the best practice. Data gathering can be done in two ways, paper, or electronics methods. Below are the recommended best practices:

- Limit information that is printed, print only when it is necessary.
- Where it is possible, promote a paper-free working environment to reduce amount of information to be printed
- In instances where information is printed, register each copy by using serial or coding method to track them on a spreadsheet.
- Only authorised persons should have access to documents and should be made aware that they are personally accountable for the security of the documents they have access to.
- Printed materials should be stored in locked file cabinet and other secure means of storage
- All printed materials that are no longer needed should be destroyed in an untraceable way (preferably by shredding).
- Rooms and offices where sensitive information is stored should be firmly locked when staff leaves such rooms or offices.
- Have a plan in place for destruction in instances of emergency or evacuation.
- All staff should be made aware of the importance of vigilance on the ingress and egress of rooms where sensitive information are stored.
- For electronic storage, emails should only be used when absolutely necessary, and caveat should be included in the message to the fact that message and/or attachment is sensitive and/or should not be redistributed or should only be shared with permission
- The use of digital security measures such as encryption of messages and/or information on digital storage facility is encouraged.
- Digital storage hardware such as flash drive, CDs and computers should be well secured.
- Computers should be pass-worded. The passwords should not be so general that everyone will have access to it. Staff should be acquainted with passwords to only the information they have right to access.
- Advance digital security measures can be taken with the use of fingerprint and biometric access system.
- Organisations can use identifiers to mask personal identities.
- Each organisation should develop their internal protocol on the duration to keep case files. However, ten (10) years is suggested as the appropriate time after which it should be destroyed, and details be transferred and kept in electronic copies.

13.4. Data Sharing Best Practices

- Complete intake forms should not be shared or transferred between agencies or organisations. This can only be done in very rare situation such as when an organisation undertaking the case management is pulling out and transferring total care and support to another organisation; or when survivor is relocating to a complete new location where another organisation will provide care/support. This should be done with the survivor's consent.
- Donors should not require that service providers to submit individual case files as part of routine reporting
- Care providers should not share or publicise the number of cases they have attended to; rather, GBV patterns, trends and risk can be shared as this will help paint a fuller picture especially when multiple sources are reviewed

and analysed together.

- In sharing of information, all guiding principles about safety, confidentially and security must be observed.

- Identifying information should not be included in information to be shared.

.

APPENDIX

APPENDIX I - CONSENT FORM (SAMPLE)

CONFIDENTIAL Form: Consent for Release of Information

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

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

(1)

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

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

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

*I would like information released to the following:

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

YES ☐ **NO** ☐

Safe shelter/house (Specify)

YES ☐ **NO** ☐

Psychosocial Support Services (Specify)

YES ☐ **NO** ☐

Health/Medical Services (Specify)

YES ☐ **NO** ☐

Law Enforcement/Security Services (Specify)

YES ☐ **NO** ☐

Legal Assistance Services (Specify)

YES ☐ **NO** ☐

Livelihood Services (Specify)

Authorization to be marked by client (or parent/guardian if client is under 18):

YES ☐ **NO** ☐

(2).

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

Authorization to be marked by client (or parent/guardian if client is under 18):

YES ☐ **NO** ☐

Signature/Thumbprint of client: _____

(or parent/guardian if client is under 18)

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

Client's Name: _____

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

Contact Number: _____

Address: _____

APPENDIX II - INTAKE AND REFERRAL FORM (SAMPLE)

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

APPENDIX III- Dignity Kit Checklist

Items listed here may be re-considered and further suggestions made that will fit into the needs of the local community

S/N			
1	**Sanitary Pads** **Option 1**: Re-washable sanitary pads **Option 2**: Disposable pads	2 packs of 6Pcs 6 packs	Should have considerations for heavy flow and normal flow
2	**Underwear** (pants at the minimum)	5 pieces	Range of sizes (Medium, Large & XL)
3	**Soap**	2 bars	
4.	**Toothpaste and Toothbrush**	1 each	
5	**Lotion/Vaseline**	500ml	
6	**Shaving Stick**	1 piece	
7	**Washing Powder**	1 pack(1Kg)	
8	**Towel/Fleece Blanket**	1 piece	
9	**Scarf /Hijab**	1 piece	
10	**Wrapper**	1 piece	
11	**Flashlight/Solar**	1 piece	
12	**Whistle**	1 piece	
13	**Carryon Bag/Case**	1 piece	

APPENDIX IV - INCIDENT REPORT FORM

General Information

Case Number: ___/__/___/___ GBV/00/00/0000	State: _____ LGA/LCD_____ Ward:_____t	Date of Interview: _____ Time:_____(24hr)

Previous Incident Numbers for this Client (if any):
_____/_____/_____ ; _____/_____/_____ ; _____/_____/_____ ; _____/_____/_____

Was this client referred to you from somewhere or by someone else? Yes ☐ No ☐

Survivor Information

Survivor code.	Age:	Date of Birth	Sex Male ☐ Female ☐
Location	Nationality	Occupation	

No. of Children:	Ages:	Head of family (self Or name, relationship to survivor):

Religion :	Education:

Status (national resident, non-national resident, refugee, IDP, repatriate, other-specify):

The Incident

Location:	Date:	Time of the Day:

Description of the incident (summarize circumstances, what exactly occurred)

Type of the Incident:

- ▫ Rape (includes gang rape, marital rape)
- ▫ Defilement
- ▫ Physical Assault
- ▫ Forced Marriage
- ▫ Denial of Resources, opportunities & services
- ▫ Psychological Abuse
- ▫ Child marriage
- ▫ Female Genital Cutting / Mutilation
- ▫ Other GBV (specify)

- ▫ Incident reported by: Survivor
- ▫ Other (specify):

Was the client referred to the recipient?

- ▫ No
- ▫ Yes

If Yes, by who?

Perpetrator code:	Nos. of Perpetrators	Age (Estimate)	Year of Birth:	Sex Male: ☐ Female: ☐
Location:	Status (national resident, non-national resident, refugee, IDP, repatriate, other-specify)	Nationality:	Education:	Occupation:

Relationship to Victim	Marital Status	Religion

If perpetrator unknown, describe him/her (height, age, complexion etc.):		
Current location of perpetrator, if known:_____ Is perpetrator a continuing threat: Yes ☐ No ☐		
Witness if any:		
Describe presence of any witness (including children):		
Name and Addresses:		
Action Taken – any action already taken as of the date this form is completed		
Reported to:	**Date Reported:**	**Action Taken/Not taken (why)***:
Police:		
Legal service centre		
Referred to*:	**Date referred*:**	**Not referred (why)*:**
Police		
Safe shelter		
Health Centre		
Other care (Specify)		
More Action Taken and Planned Action (as at date this form is completed)		
Physical security needs assessment and immediate safety plan:		
Has the victim/survivor received any kind of counseling-if yes, by who? ☐ No ☐ Yes, by _____		
Is victim/survivor going to report the incident to police? Yes ☐ No ☐		
Is she/he seeking action by elders/Family/Community Yes ☐ No ☐		
What follow-up will be done by the GBV service provider/social worker?		
Form completed by (names):	Designation	Signature (and Stamp), Place name

APPENDIX V - REFERRAL FORM

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

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

Survivor Information: (All personal information is OPTIONAL depending on level of detail the client consents to disclose) Note: For all external referrals, the use of survivor codes instead of names should be discussed and agreed by all actors.

Name/Survivor Code:
Sex:
DOB:
Language:
Address:
Phone:

Background Information/Reason for the Referral:

(problem description, duration, frequency, etc. only relevant for the referral)

Background Information/Reason for the Referral:

(problem description, duration, frequency, etc. only relevant for the referral)

Name of primary caregiver: Contact information for caregiver:_____/_____

Relationship to child:

Caregiver is informed of referral? Y☐ ☐o

(If no, explain)_____/_____

Services already provided: (include any other referrals made – limited to information only relevant for the referral)

Agency	Support	**Date (incl. ongoing)**

Services Requested:

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

ADDITIONAL SPECIFIC NEEDS OF THE SURVIVOR

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

IMPORTANT
Also refer the case to the lead GBV Case Management agency in the location if - You are unsure how to support a particular person, - Immediate physical security options (including relocation) are required, - Best Interest Assessment (BIA/BID) for a child is necessary - Police/Legal Action is required - Emergency protection cash assistance for transport is necessary

Consent to Release Information (Read with survivor and answer any questions before s/he signs below)
I, _____, understand that the purpose of the referral and of disclosing this information to _____ is to ensure the safety and continuity of care among service providers seeking to serve this family/person. The service provider, _____, has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information. Signature of Responsible Party: Date:

Details of Referral :
Survivor has been informed of referral? Yes No (If no, explain) _____ If consent has not been signed (especially if referral from hotline), survivor has been explained the process and has verbally consented to release information? Yes No Any contact or other restrictions? Yes No (If yes, explain) _____
For Sexual Exploitation and Abuse, complete the Inter Agency SEA Intake and Referral Form and send to the following confidential email address: nga.psea@humanitarianresponse.info

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

APPENDIX VI CASE PLANNING FORM

Survivor Code: **Caseworker Code:** **Date:**

ACTION POINTS/GOALS	WHO	BY WHEN

Follow up meeting is scheduled for:

Date	
Time	
Location	

Caseworker signature and date: **Client/Guardian signature and date**

_____ _____ _____

APPENDIX VII CASE FOLLOW UP FORM

Survivor Code: **Caseworker Code:** **Date:**

Progress Towards Goals			
Evaluate progress made towards action/goals agreed on in the Case Action Plan Form	**Not Met**	**Met**	**Explain**
Safety			
Health Care			
Psychosocial Support			
Access to Justice			
Other (list other goals made here)			
Other Observations/Caseworker notes			

RE-ASSESSING SAFETY				
	Yes	**No**	**Explain**	**Additional Intervention Planned**
Are there new or continued risks of danger at home?				

Are there any new or ongoing safety issues the survivor is facing in the community?				

FINAL ASSESSMENT

	Yes	**No**	**Explain**	**Additional Interventions Planned**
A. **Safety situation is stable** Survivor is physically safe, and/or has a plan to keep physically safe				
B. **Health situation is stable** Survivor has no medical problems that require treatment				
C. **Psychosocial wellbeing has improved** Survivor is engaging in regular behavior; has a safe person to talk to				
D. **Access to Justice secured (if applicable)**				
E. **Other Intervention needed**				

Follow up meeting is scheduled for (date/time/location): _____

APPENDIX VIII CASE CLOSURE FORM

Survivor Code:	**Caseworker Code:**
Case Opening Date:	**Case Closure Date:**

CASE CLOSURE:

Summarize the reasons why the case is being closed. Comment on the progress made toward goals in the action plan. Where necessary, include provisions for continued services, listing agencies and contact persons.

Case closure Checklist:

(1) Safety plan has been reviewed and is in place. YES_____ NO _____
Explain :_____

(2) Person has been informed she or he can resume services at anytime. YES_____NO____
Explain: _____

(3) Case supervisor has reviewed case closure/exit plan. YES_____ NO
Explain: _____

Explanation notes here:

Caseworker Signature/Date: _____

Supervisor Signature/Date: _____

APPENDIX IX CRITERIA: MINIMUM REQUIREMENT TO BE PART OF THE GBV PATHWAY

S/N	CRITERIA	MINIMUM REQUIREMENT
1	PRESENCE	To be part of the referral pathway, organizations are required to have operational presence in Lagos State as well as access to affected population either directly or through implementing partners. Participate in local/location specific GBV coordination mechanisms and report on their activities
2	LEGAL STATUS	Referral pathways only comprise those organizations that for legal status are defined as a government institution, NGO or a humanitarian organization/service provider and those that, for mandate, have as first responsibility to respond to needs of the affected population.
3	ADHERANCE TO HUMANITARIAN PRINCIPLES	To be part of the referral pathway, an organization (and its implementing partners) must have a Code of Conduct and PSEA policy in place.
4	COMMITMENT	Management of an organization must: □ Endorse the SOPs; □ Ensure adherence to the minimum standards in GBV prevention and response; □ Guarantee that GBV guiding principles, minimum criteria and information sharing protocol are well understood and respected among staff; and, □ Ensure relevant personnel inside the organization are kept aware of and comply with the SOPs and referral pathways.
5	MEMBERSHIP	Organizations (and their implementing partners) that: □ Are part of the GBV SS and that deliver GBV response services; and/or, □ Are part of Health Sector and that deliver CMR or more general clinical care for GBV survivors □ Are a key protection agency that cooperates with the GBV SS in responding to the needs of survivors
6		Services included in the referral pathway are: □ Case management for GBV survivors □ CMR for GBV survivors □ Mental health for GBV survivors □ Focused PSS for GBV survivors □ Safe shelters for GBV survivors

6		Services included in the referral pathway are: □ Case management for GBV survivors □ CMR for GBV survivors □ Mental health for GBV survivors □ Focused PSS for GBV survivors □ Safe shelters for GBV survivors □ Psychosocial support and recreational activities □ Vocational training, livelihood and economic empowering programmes for GBV survivors or women at risk □ Material assistance for GBV survivors (e.g., cash, shelter, NFI, dignity kits, hygiene kits □ Law enforcement services □ Legal and judicial services
7	CAPACITY	To make and receive the referral of GBV survivors, organizations need to have following capacities: □ Structure (i.e., dedicated personnel, tools, internet or phone connection) □ Infrastructure (i.e., specialized centres, confidential space) □ Technical expertise (i.e., trained and experienced management, trained services providers, access to training) If for a specific and temporary situation those capacities are not available, organizations need to aim at ensuring adherence to the SOPs as much as possible When GBV guiding principles cannot be guaranteed due to the lack of capacities, organizations should not deliver GBV response services
8	HUMAN RESOURCES	To ensure good quality of services, organizations should have trained and dedicated staff for GBV response services. To be part of the referral pathway, organizations must provide at least two Managerial Focal Points and two Service Focal Point through the service-mapping tool
9	MINIMUM STANDARDS	The referral of GBV survivors and the delivery of services are based on the minimum standards described in these SOPs. To be part of the referral pathways, organizations must agree with and endorse the content of the SOPs
10	KNOWLEDGE	GBV services providers should have been trained in their areas of expertise and be professionally prepared to deal with GBV survivors.

REFERENCES

- National Standard Operating Procedures for Prevention and Response to Sexual Gender-Based Violence in Liberia (2009) available at https://www.law.berkeley.edu/wp-content/uploads/2015/10/Liberia_MOGD_National-SOPs-for-Prevention-Respnse-to-SGBV_2009.pdf

- STANDARD OPERATING PROCEDURES (SOPs) FOR GENDER-BASED VIOLENCE (GBV) PREVENTION AND RESPONSE: NIGERIA (2019), developed by the GBV Sub Sector in Collaboration with United Nations Population Fund (UNFPA), International Medical Corps (IMC) and Plan International: Validated & Endorsed by the GBV SS partners on 10th October 2019 available at https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/nigeria._sops_gbv_prevention_response_2019.pdf

- STANDARD OPERATING PROCEDURES (SOP) FOR THE NATIONAL GENDER BASED VIOLENCE DATABASE (NGBVD) available at http://ngbvd.mglsd.go.ug/docs/3801STANDARD%20OPERATING%20PROCEDURES%20FOR%20THE%20NATIONAL%20GENDER%20BASED%20VIOLENCE%20DATABASE.pdf

- STANDARD OPERATING PROCEDURE (SOPS) for Law Enforcement in Handling Human Trafficking Cases in Zambia - in accordance with the Zambia Anti-Human Trafficking Act No. 11 of 2008

- STANDARD OPERATING PROCEDURE (SOPS) to Combat Human Trafficking Cases in Ghana (2017) available at https://reliefweb.int/sites/reliefweb.int/files/resources/sop_ghana_1.pdf

- UNHCR Standard Operating Procedures for Prevention of and Response to Gender-Based Violence in Kurdistan Region of Iraq, GBV Sub-Cluster available at https://reliefweb.int/sites/reliefweb.int/files/resources/gbv_sop_-_kri.pdf

- UNHCR National Guidelines for Standard Operating Procedures ((SOPs) for Prevention of and Response to Gender-Based Violence In Humanitarian Settings (Country: Pakistan)

- WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (WHO, 2007) available at

- THE MANAGING GENDER-BASED VIOLENCE PROGRAMMES IN EMERGENCIES E-LEARNING AND COMPANION GUIDE available at https://extranet.unfpa.org/Apps/GBVinEmergencies/index.html

- THE REPUBLIC OF UGANDA- MINISTRY OF GENDER, LABOUR AND SOCIAL DEVELOPMENT Gender Based Violence Incident Report Form available at http://gbvguidelines.org

- Interagency Standing Committee (IASC). Guidelines for Integrating Gender-based Violence Intervention in Humanitarian Action. Geneva, IASC (2015) available at http://gbvguidelines.org

CEWHIN
Centre for Women's Health and Information (CEWHIN)
34, McNeil Road, Off Montgomery Road, Sabo, Yaba, Lagos State.
E-mail: info@cewhin.com, cewhin@yahoo.com
Tel: +234 907 418 7490 | Website: http://www.cewhin.com
@cewhin @cewhin @cewhin_ng @cewhin