STANDARD OPERATING PROCEDURES (SOPs) FOR GENDER-BASED VIOLENCE (GBV) PREVENTION AND RESPONSE: NIGERIA

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
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INTRODUCTION

The Gender-Based Violence (GBV) Standard Operating Procedures (SOPs), are developed/revised to facilitate multi-sectoral referral mechanisms for survivors, women, men, boys and girls at risk. GBV is a life threatening protection, health, and human rights issue that can have devastating impact on women and children in particular, as well as families and communities. These SOPs describe clear procedures, roles, and responsibilities for all actors, who agree to the same procedures, guiding principles and working together for the best interest of women, men, boys and girls.

The SOPs were first developed in April, 2016 with support from the Gender Based Violence Area of Responsibility (GBV AoR) under the guidance of the Ministry of Women Affairs and Social Development (MoWASD) and UNFPA Nigeria, for Borno, Adamawa and Yobe states. They have been instrumental in guiding referrals and response to cases of GBV. The need for revision and harmonization of the SOPs was identified by partner’s following developments in the context of the conflict. This revision coincides with the with the review of the GBV Sub Sector Strategy and incorporates some key components that were missing in the first version of the SOPs, guided by the GBV Strategic Advisory Group and the MoWASD.

The revision of these SOPs were made possible with financial and technical support from United Nations Populations Fund (UNFPA), the International Medical Corps (IMC) and Plan International. A series of consultations were conducted in Maiduguri for stakeholders in Borno state in May, 2019, in Yola for stakeholders in Adamawa and Yobe states in June, 2019. A final validation workshop was held in Maiduguri on 10th October 2019 to facilitate collective reflection on state level discussions and validate these SOPs.

The SOP has standardized procedures for referrals of GBV cases for Nigeria’s response. The standards of practice and guiding principles are in line with what is globally acceptable and applies to all actors involved GBV programming in Borno, Adamawa and Yobe States. The main document offers harmonized templates that can be adapted for field level referrals. However, the details such as referral directories, referral pathways are localized to each state and/or location.

Purpose:

The GBV prevention and response Standard Operating Procedures (SOPs) is a technical guidance document that aims to ensure that all survivors of GBV receive prompt and comprehensive response from service providers that meets their needs from the first point of contact onwards. It is an agreement of cooperation among the respective sectors, ministries, agencies and Non-Governmental Organisations (NGOs) /Community Based Organisations (CBOs) to ensure an effective response to, and coordination of, services for survivors of Gender Based Violence. The purpose is to establish a clear reporting and referral system so that GBV survivors and others know to whom they should report and what sort of assistance survivors can expect to receive from the health, social welfare, law enforcement, legal, justice and other sectors.

Specific Objectives:

- Survivors of GBV and those at risk will receive prompt and coordinated response from service providers
- A holistic and comprehensive support and services are being provided for survivors of GBV. This will include medical care, psychosocial support, protective care, and legal services (legal advice, representation, mediation and litigation)
- Standards of professional practice are prescribed and followed with regards to confidentiality, information sharing and recording of sensitive information, avoiding conflicts of interest
- Raise awareness among all key stakeholders about GBV and the Referral Pathways
- Develop a framework for monitoring and evaluation

Scope

These SOPs describe the roles, responsibilities, guiding principles, and procedures for prevention of and response to any form of gender-based violence affecting the community(ies). Although there is special emphasis on sexual violence,
actions are not to be limited to only sexual violence, but reflect a more comprehensive prevention and response interventions (humanitarian – development nexus).

These SOPs pertain to Borno, Adamawa and Yobe States and will apply to all the field level response areas. Details of service providers or actors however will vary according the specific location. Throughout this SOP, the female voice is used (“her”, “she”) solely for simplicity and ease. The entire SOP should be taken to apply to any survivor/victim of GBV - women, girls, men, or boys.

The intended users of the SOPs are all humanitarian actors, sectors and service providers that are engaged in GBV response and prevention programming in areas Borno, Adamawa and Yobe States.
### DEFINITION OF TERMS/CONCEPTS

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

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Victim</td>
<td>A person against whom an offence is committed.</td>
</tr>
<tr>
<td>Survivor</td>
<td>Refers to any person – girl, woman, boy, man, child, adolescent, adult who suffers any act of violence or rights violation. A preferred term for a person who has lived through an incident of Gender-Based Violence.</td>
</tr>
<tr>
<td>Perpetrator</td>
<td>A person, group or institution that inflicts, supports or condones violence or other abuse against a person or groups of persons.</td>
</tr>
<tr>
<td>First Point of Contact</td>
<td>The first point of contact is defined as any person(s) to whom the survivor first discloses or reports an incident of abuse.</td>
</tr>
<tr>
<td>Actor(s)</td>
<td>Refers to individuals, groups, organizations, and institutions involved in preventing and responding to gender based violence.</td>
</tr>
<tr>
<td>Incident</td>
<td>Refers to the specific act of gender based violence or rights violation.</td>
</tr>
<tr>
<td>‘At risk’ group(s)</td>
<td>Group(s) of individuals more vulnerable to harm than other members of the population because they hold less power, are more dependent on others for survival, are less visible to relief workers, or are otherwise marginalized.</td>
</tr>
<tr>
<td>GBV management</td>
<td>A structured method for providing help to a survivor. It involves one organization, usually a psychosocial support or social services actor, taking responsibility for making sure survivors are informed of all the options available to them; and that issues and problems facing a survivor and their family are identified and followed up in a coordinated way, as well as providing the survivor with emotional support throughout the process.</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>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. 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.</td>
</tr>
<tr>
<td>Disclosure</td>
<td>The process of revealing information about a GBV experience or incident. Disclosure in the context of GBV abuse refers specifically to how a person (e.g., caregiver, health worker, social worker, member of a women’s group, friend, teacher) learns about an incident of GBV directly from a survivor. The terms “identification” and “involuntary disclose” are commonly used in the case of children when they are too young to speak about the incident and when a third person identifies the violence.</td>
</tr>
<tr>
<td>Gender based violence Information Management Services</td>
<td>A system for collecting, storing and sharing key information on GBV incidents. It helps harmonize data collection on GBV in humanitarian settings, to provide a simple system for GBV project managers to collect, store and analyse their data, and to enable the safe and ethical sharing of reported GBV incident data. The system is intended to both 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.</td>
</tr>
<tr>
<td>Informed assent</td>
<td>The expressed willingness to participate in services. This applies to younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services. Informed assent is therefore the expressed willingness of the child to participate in services.</td>
</tr>
<tr>
<td>Informed consent</td>
<td>Approval or assent, particularly and especially after thoughtful consideration. Free and informed consent is given based upon a clear appreciation and understanding of facts,</td>
</tr>
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</table>
implications and future consequences of an action. In order to give informed consent, the individual concerned must have all adequate relevant facts at the time consent is given, and be able to evaluate and understand the consequences of an action. They must also be aware of and have the power to exercise their right to refuse to engage in an action and/or to not be coerced. Children are generally considered unable to provide informed consent because they may not have the ability and/or experience to anticipate the implications of an action, and because 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.

**Mandatory reporting**

Laws and policies that mandate certain agencies and/or persons to report actual or suspected child abuse. Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person. Mandatory reporting is a responsibility for humanitarian actors who hear about and/or receive a report of sexual exploitation or abuse committed by a humanitarian actor against a member of the affected population.

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**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 (gender) differences between males and females. Acts of GBV violate a number of universal human rights protected by international instruments. The term “gender-based violence” highlights the gender dimension of these types of acts; in other words, the relationship between male and female. It reveals the females’ subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of gender-based violence, especially sexual violence.

The nature and extent of specific types of GBV vary across cultures, countries, and regions.

**Examples include:**

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

**Sexual Assault/violence** including sexual exploitation/abuse and forced prostitution: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. This incident type does not include rape, i.e. where a form of penetration has occurred.

**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.

** Forced/early marriage:** It refers to marriage of an individual against her or his will. Formal marriage or informal union under the age of legal consent is a reality for both boys and girls, although girls are disproportionately the most affected (UNICEF, Child marriage, 2012).

**Denial of resources or opportunities or service:** withheld by an intimate partner or family member, household resources (to the detriment of the family’s well-being), prevented by one’s intimate partner to pursue livelihood activities.

**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.

**GUIDING PRINCIPLES**

The survivor-centred approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor’s rights are respected,
safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a survivor’s recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person’s capacity to make decisions about possible interventions¹.

**Guiding principles for all actions**
Organizations that agree to adhere to a set of guiding principles aimed at ensuring staff are committed to integrating GBV into their work and are adequately skilled to do so; and aimed at ensuring their programmes are gender sensitive, collaborative and participatory.

Organizations should:

- Integrate and mainstream GBV interventions into all programmes and all sectors.
- Establish and maintain carefully 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.
- Engage the community fully in understanding and promoting gender equality and gender power relations that protect and respect the rights of women and girls.
- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programmes through the systematic use of participatory methods.
- Ensure accountability at all levels to local communities and among all humanitarian actors working in any sector.
- Ensure all staff understand and adhere to ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies².
- Ensure all staff, contractors and volunteers involved in prevention of and response to GBV understand and sign a code of conduct on Protection from Sexual Exploitation and Abuse/Sexual Harassment or similar document setting out the same standards of conduct.

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

**Safety and Security:** Ensure the safety of the survivor, child and family at all times. Remember that s/he may be frightened, and needs assurance that s/he is safe. In all types of cases, ensure that s/he is not placed at risk of further harm by the assailant. If necessary, undertake a safety assessment and ask for assistance from security, police, elders, community leaders or others who can provide security. Maintain awareness of safety and security of people who are helping the survivor, such as family, friends, counsellors, health care workers, etc.

**Confidentiality:** Respect the confidentiality of the survivor, child and their family at all times. If the survivor gives his/her informed consent, share only relevant information with others for the purpose of helping the survivor, such as referring for services. All written information about survivors must be maintained in secure, locked files. If any reports or statistics are to be made public, only the actors who report data each month will have the authority to release such information, guided by the ISP. All identifying personal information (name, address, etc.) will be withheld in the reporting, compilation and sharing of data. Encourage other community members and humanitarian actors to respect

¹IASC, Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery, 2015, p.47.
the confidentiality of the survivor and not gossip about a case which may increase the stigma of the survivor and discourage other survivors from seeking help in future. When relating to children make sure they understand that you have to share the information with their caretakers or other appointed legal guardian to ensure the safety and security of the child.

**Informed Consent:** All actors must receive informed consent from the survivor, or legal guardian if working with a minor, prior to any response service or sharing of information. If the survivor cannot read and write an informed consent statement will be read up to the survivor and a verbal consent will be obtained. The survivor should have the option to provide limited consent where they can choose which information is released and which is kept confidential. The objective of informed consent is that the survivor understands what s/he is consenting and agreeing to. Children must be consulted and given all the information needed to make an informed decision using child-friendly techniques that encourage them to express themselves. Their ability to provide consent on the use of the information and the credibility of the information will depend on their age, maturity and ability to express themselves freely.

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

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

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

**Information:** All survivors and those at risk have the right to accurate information on what services are available, how to reach or access the services, the potential risks and consequences of accepting additional services and not accepting additional services. Make sure information is given to children in a manner they understand and is child friendly. Information should be honest and complete.

**Best Interest of the Child:** In all cases concerning a child, the best interest of the child should be the primary consideration. Apply all the listed guiding principles to children, including their right to participate in decisions that will affect them. A child should be listened to and believed in, and their concerns should be taken seriously. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding guide and the appropriate procedures should be followed. Best interest determination guidelines can also be consulted.

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

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

A survivor-centred approach involves designing and developing programming that ensures the rights and needs of GBV survivors come first and foremost. This means the survivor should be placed at the centre of each step of the response process, and that every decision should be driven by the survivor’s needs, wishes and capacities.
The survivor-centred approach aims to create a supportive environment in which a survivor’s rights are respected and in which the survivor is treated with dignity and respect. This approach helps promote a survivor’s recovery and empower them to make decisions about possible recovery interventions.

The survivor-centred approach is considered essential for the following reasons:

- To protect survivors from further harm
- To provide survivors with the opportunity to talk about their concerns without pressure
- To assist survivors in making choices and in seeking help if they want help
- To cope with the fear that they may have about negative reactions (from the community or their family) or being blamed for the violence
- To provide basic PSS/PFA to the survivor
- To give back to the survivor the control they may have lost during the GBV incident

**Care for child survivors**

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

**Work according to the best interests of the child:** This important principle should be applied both to decisions relating to individual children and to broader policy matters and decisions relating to groups of children. In each and every decision affecting children, the various possible solutions must be considered and due weight must be given to the child’s best interests. The decision about how to establish a child’s best interests can often be difficult, and no single answer may be obviously and indisputably correct. There are many factors that have to be considered, including age, sex, cultural background, general environment and past experiences of the child. Any interpretation of this principle must be made in the spirit of the Convention on the Rights of Children, and must give due regard to expert advice from both legal and child development perspectives.

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

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

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

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

In the event that service providers are required under local law to report child abuse to the local authorities, mandatory reporting procedures should be communicated to the children and their caregivers at the beginning of service delivery. In situations where a child’s health or safety is at risk, limits to confidentiality exist in order to protect the child.

**Involve the child in decision-making:** Children have the right to participate in decisions that have implications in their lives. The level of a child’s participation in decision-making should be appropriate to the child’s level of maturity and

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3 Currently there is no mandatory requirement in Borno, Yobe and Adamawa States. However, initiatives are underway to facilitate the ratification of the Child rights and GBV protection laws. In the event this becomes a requirement, actors are required to adjust accordingly.
age. Listening to children’s ideas and opinions should not interfere with caregivers’ rights and responsibilities to express their views on matters affecting their children. While service providers may not always be able to follow the child’s wishes (based on best interest considerations), they should always respect, empower and support children, and deal with their concerns in a transparent manner. In cases where a child’s wishes cannot be prioritized, the reasons should be explained to the child.

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

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

- Treating them with dignity and encouraging others to do the same;
- Helping them participate in family and community life; and,
- Helping them build and maintain healthy relationships.
DISCLOSURE PROCEDURES

Understanding the terminology

**Disclosure.** The term disclosure refers to an adult survivor’s choice to share that they have experienced GBV to someone. Survivors have the right to disclose an incident to anyone. They may disclose their experience to a trusted family member or friend, or seek help from an individual or organization in the community. They have the right to disclose as little or as much of what happened to them, and to choose when to disclose information.

**Identification.** The term identification refers to the situation where other people (e.g., friends) inform a service provider that another person has experienced GBV.

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

Preparing to receive survivors

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

- Train all staff on GBV guiding principles and standard operating procedures relevant to their specialization.
- Ensure all staff know the GBV referral focal points (RFPs) for their location and how to access the referral pathways online using the request form available at this link [https://www.humanitarianresponse.info/en/operations/nigeria/document/first-responder](https://www.humanitarianresponse.info/en/operations/nigeria/document/first-responder)

**Disclosure procedures**

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

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

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

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

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

Actors should know that sharing any information about a GBV incident may pose serious and potentially life-threatening consequences for the survivor and for those helping them. They should share only essential information on how service providers can get in touch with the survivor and important safety issues relating to the survivor’s situation. The table below explains the disclosure procedure and steps for all actors.
### Figure 1: Disclosure Procedures

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>ACTIONS</th>
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</thead>
</table>
| **Prepare**¹  | • Be aware of available services.  
• Know how to communicate with survivors in a survivor-centred manner.  
• Increase your knowledge and skills as a non GBV practitioner.                                                                                           |
| **Welcome**   | • Find a safe and quiet 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 if it is safe to do so.  
• If they are in danger, identify together actions to help them (e.g., key people to contact, safer locations).  
• Try to keep the person safe.  
• If the survivor is very distressed, help them to calm down.  
• Ask what the survivor needs to be comfortable (clothing, blanket, 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 reactions.  
• 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 the survivor it is not their fault.  
• Inform them it is common to feel strong negative emotions in these situations.                                                                      |
| **Provide information** | • Inform the survivor they are entitled to protection from violence, abuse and exploitation, and to receive care and support.  
• Inform them of the services available, and the benefits and consequence 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 inquire.  
• For sexual violence survivors, provide information on health services.  
• Explain to the survivor the importance of seeking health care within 72 hours to minimize risks of sexually transmitted diseases (including HIV/AIDS) and unwanted pregnancies.  
• For adult survivors, inform them they have the right to decide what services they wish to receive and with whom they wish to share information.  
• Give the survivor time to take breaks and ask for clarifications.  
• Respect the survivor’s right to decide what support they need.  
• Do not give advice or your opinion on what the survivor should do.                                                                                   |
| **Referral**  | • If the survivor requests or consents to access to services, follow the SOPs for procedures for referral.                                                                                               |

<table>
<thead>
<tr>
<th>Close</th>
<th>Refer the survivor to a GBV Case management service provider, if available in your location for follow up and support.</th>
</tr>
</thead>
</table>

- Finish the disclosure in a positive way
- Reaffirm they are entitled to protection from violence, abuse and exploitation, and to receive care and support.
- Reaffirm it is not their fault.
- Reaffirm it is common to feel strong negative emotions in these situations.
- Reaffirm they have the right to live free from violence and risk of violence.
REFERRAL PROCEDURES

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

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

It’s important that the survivor is able to access various entry points for care according to his/her own wishes/needs. In establishing a referral system there should NOT be a designated first point of contact but multiple entry points from which the referral system proceeds. All service providers and community should be aware of the system and able to activate referrals whether or not they are the first point of contact for a survivor.

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

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

Types of referrals

Referrals can happen in many different directions amongst different actors. The table below indicates types of possible referrals.

Figure 2: Types of referrals

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
<th>REFERRAL TYPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any actor or community members</td>
<td>Specialised service provider and/or GBV case management actors</td>
<td>Professional care and GBV case management</td>
</tr>
<tr>
<td>GBV case management actors</td>
<td>GBV case management actors</td>
<td>It may be more appropriate for another GBV specialist to provide case management (e.g., in another area).</td>
</tr>
<tr>
<td>Child Protection case management actors&lt;sup&gt;5&lt;/sup&gt;</td>
<td>GBV case management actors</td>
<td>It may be more appropriate for GBV specialist to provide case management to a child and adolescent survivor of GBV, where the CP case worker does not have specific skills for GBV</td>
</tr>
<tr>
<td>GBV case management actors</td>
<td>Child Protection case management actors</td>
<td>A child survivor of GBV, especially sexual violence may have other additional needs that can better be met or addressed by a Child protection case worker</td>
</tr>
<tr>
<td>Specialised service provider and/or GBV case management actors</td>
<td>Multi-sectoral response services</td>
<td>To provide timely and quality care to GBV survivors such as medical services.</td>
</tr>
</tbody>
</table>

<sup>5</sup> These SOPs recognise the need to coordinate on meeting/responding to the needs of child and adolescent survivors of GBV with other child protection concerns/needs and call for close collaboration between GBV and CP actors.
Steps in making referrals:
All entry points should observe the following standard steps of referral:

**Information, agreement and informed consent.** The survivor should be informed about possible referrals for services in a safe, ethical and confidential manner. Prior to any other step of referral, survivor’s agreement should be obtained, as well as the informed consent for information sharing should be undertaken. The survivor has the right to choose to which service will be referred and to ask for limitations on the shared information. See a sample of consent form in annex 1.

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

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

**Safety assessment:** All actors have an important role to play in supporting a survivor through jointly assessing potential risks of further violence, supporting her in her safety planning, as well as offering referrals to a shelter (where appropriate/available). It enables service providers to support the survivor in identifying measures to increase her safety and to raise her awareness of the risk.

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

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

**Confidentiality & Exceptions**
Confidentiality reflects the belief that people have the right to choose to whom they will, or will not, tell their story. Maintaining confidentiality means not disclosing any information at any time to any party without the informed consent of the person concerned. It promotes safety, trust and empowerment. It is an important part of the survivor-centred approach, and should be given consideration at all times.

Confidentiality might need to be broken in certain circumstances. These are:

- If the survivor threatens their own life or is directly threatening the safety of others, in which case referrals to lifesaving services can be sought.
- If the survivor is a child, when there are concerns for his/her health or safety.
- When there are mandatory reporting policies for cases of sexual exploitation and abuse that involve humanitarian workers.

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Standard Operating Procedures for GBV Prevention and Response - Nigeria
A survivor should be informed about any exception to confidentiality.

**Informed consent**

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

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

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

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

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

The steps to ensure informed consent.

**Step 1: Provide all information:** To ensure consent is truly informed consent, a humanitarian actor must provide all possible information and options available to the survivor. They must explain what is going to happen to the survivor after the referral. They must also explain to the survivor that they have the right to decline or refuse any part of any services.

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

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

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

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

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

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

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

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

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

Informed consent for survivors with disabilities

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

The Convention on the Rights of Persons with Disabilities states that an individual cannot lose their legal capacity to make decisions simply because they have a disability\(^6\). It is therefore important to assume initially that all adult GBV survivors with disabilities can provide informed consent, and to follow the same procedures as described above. Some additions to these procedures are:

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

Informed consent/assent for child survivors

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

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


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

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

Figure 3: provides a summary of the guidelines for obtaining informed consent/assent from children.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>child Caregiver</th>
<th>If no Caregiver Or Not in the Child’s Best Interest</th>
<th>Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>-</td>
<td>Informed consent</td>
<td>Written consent</td>
</tr>
<tr>
<td>6-11</td>
<td>Informed assent</td>
<td>Informed consent</td>
<td>Oral assent, Written consent</td>
</tr>
<tr>
<td>12-14</td>
<td>Informed assent</td>
<td>Informed consent</td>
<td>Written assent, Written consent</td>
</tr>
<tr>
<td>15-18</td>
<td>Informed consent</td>
<td>Obtain informed consent with child’s permission</td>
<td>Child’s informed consent and sufficient level of maturity takes due weight</td>
</tr>
</tbody>
</table>

Obtaining Referral Pathways

All humanitarian actors should know how to refer a GBV survivor for support. It is very important to take prompt action in order for the GBV survivor to access quality and timely care. Timely referrals can save lives and prevent further harm and medical consequences in cases of sexual violence and other severe cases. The GBV SS has developed referral guide and pathways (Annex IV and V) which can be accessed by all actors. Updated referral pathways can be accessed from https://www.humanitarianresponse.info/en/operations/nigeria/document/gbv-referral-pathways

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

- **Presence.** Is the service regularly available and fully function on the ground?
- **Geographical location.** Does the service reach the population it is meant to serve?
- **Accessibility.** Can survivors and/or communities access this service freely, safely and confidentially?
- **Accountability.** Who is responsible for following up this service?

Survivor Referral Options

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

1. The survivor can contact or go directly to the service provider and/or GBV case management actor.
2. The humanitarian actor can help the survivor access the services by making a referral.

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

Figure 4: Options for survivors’ referral for humanitarian actors who are not GBV actors providing case management
<table>
<thead>
<tr>
<th>Accompany the survivor</th>
<th>Emergency or urgent GBV cases</th>
<th>Accompany the survivor to the relevant service provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral by phone using the Referral Pathways</td>
<td>Emergency, urgent or moderate cases if accompanying the survivor is not possible or is not in their best interest.</td>
<td>Any humanitarian actor can call any number in the focal point list to receive direct support for the GBV survivor, or relevant information and assistance to refer the survivor to a GBV specialist.</td>
</tr>
<tr>
<td>Referral by email or messaging application</td>
<td>For moderate risk cases</td>
<td>When using email for referral, it should only be sent to the relevant focal point, and others who are not involved in managing the case should not be copied.</td>
</tr>
</tbody>
</table>

**Non-availability of Services**

It might be the case that one or more services are not available or not accessible at a given time. It is important not to raise unrealistic expectations for a survivor about what services and support they may not be able to receive. It is therefore important all actors maintain up-to-date knowledge about what community and GBV specialized services are operating in their areas. When GBV specialized services are not available, a survivor should still have access to information to ensure their safety and basic emotional support. As the situation in the field is very fluid and service availability may change quite fast, humanitarian actors should seek to remain updated on GBV specialized services available. Referral pathways produced by the GBV SS are updated on a quarterly basis.

**Refusal of Services**

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

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

**Mandatory Reporting:**

Incidents of Sexual Exploitation and Abuse (SEA) involving humanitarian workers MUST be reported according to the UN Secretary General’s Bulletin on Sexual Exploitation and Abuse, 2003. All actors should be aware of the SOPs for inter-agency SEA Community Based Complaints Mechanisms (CBCM) and their organisation’s internal policies regarding reporting cases of SEA. In case of SEA incident, referring the survivor for appropriate response service should be prioritised. The actors should then explain to the survivor the responsibility to report, which is guided by the Zero Tolerance approach to SEA and what the survivor should expect out of the process. With survivor’s consent, the SEA incident should be reported confidentially, by filling in the inter agency SEA intake and referral form (Annex III) and submitted through the organisations PSEA Focal Point or through the inter agency PSEA coordinator (See the inter agency Referral System for SEA Annex V).

**Informed Consent of the Survivor Vs Mandatory Reporting:** In all cases, it’s important to facilitate informed consent of the survivor, without comprising the mandatory requirement for reporting. The IASC core principles make it...
mandatory for all humanitarian workers who become aware of SEA to report immediately through the established reporting mechanisms. The survivor has the right to or not to be involved in the reporting and investigation process of the SEA case. In the event the survivor wishes not to be involved, the survivors’ access to services should still be prioritised and facilitated while the incident should be referred without his/her names and identification.

All actors should ensure that all its personnel are fully informed: about their duty to report any concerns, suspicions they have or allegations or complaints they become aware of; of the agency’s complaint and response policy and procedures; and of the role and how to contact its PSEA Focal Point or manager; and the established SEA reporting and investigative body, as applicable.
ROLES AND RESPONSIBILITIES: MULTI SECTORAL SUPPORT FOR GBV SURVIVORS

Not all GBV survivors want or need assistance. Many survivors of GBV will recover without specialist support. For some, services such as social support, psychological first aid (PFA) and clinical health interventions, among others will be of benefit.

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

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

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

- Assistance should never stigmatize GBV survivors by identifying them as survivors in the specific services they receive or at the locations in which services are provided.
- Assistance should not expose survivors to additional risks (e.g., domestic violence or robbery after receiving cash or vouchers).
- Assistance provided by other sectors should be based on the case manager’s assessment and evaluation of the survivor’s needs and context. The case manager will still be the responsible person for ensuring quality of assistance and follow-up in line with a survivor-centred approach.
- Assistance should be considered part of the healing process, aimed at addressing immediate needs related to the GBV incident, within a specific timespan, and in line with the action plan agreed between the case manager and the survivor – where appropriate.
- Assistance should be guided by the principles of confidentiality, safety, respect and non-discrimination.

GBV CASE MANAGEMENT

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

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

GBV Case Management Competencies

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

- Concentrate on the survivor’s immediate needs, skills and capacities when the situation is particularly insecure. This will involve, for example, conducting safety planning and providing contacts for essential services.
- Ensure timeliness of the response. Minimizing the time it takes to arrange all services is important so survivors are supported as quickly as possible.
- Ensure that case management is provided by trained, well supervised and experienced staff who have the time and resources to carry out their work.
- Case management should take place as much as possible in safe and confidential spaces.
- Avoid home visits to survivors. If safe spaces are not available or accessible, identify another community or service provider centre.

**HEALTH/MEDICAL CARE**

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

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

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

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

**Figure 4: key actions involved in the provision of clinical care**

<table>
<thead>
<tr>
<th>STEPS</th>
<th>SURVIVOR-CENTERED APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation for an examination</td>
<td>• Introduce yourself.</td>
</tr>
<tr>
<td></td>
<td>• Limit the number of people in the room to the minimum necessary. If the survivor wishes, ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend).</td>
</tr>
<tr>
<td></td>
<td>• Determine the best way to communicate and adapt to the survivor’s communication skill level and language. Avoid medical terminology and jargon.</td>
</tr>
<tr>
<td></td>
<td>• Obtain informed consent (or a parent’s informed consent in the case of a child).</td>
</tr>
<tr>
<td></td>
<td>• Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you will give. Make sure the survivor understands everything.</td>
</tr>
</tbody>
</table>
- Reassure the survivor they are in control of the examination. Explain that they can refuse any aspect of the examination they do not wish to undergo, and that this will not affect their access to treatment or care.
- Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges.
- Provide psychological first aid.
- Ask the survivor if they have any questions.

### Taking the history
- If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case.
- Avoid any distraction or interruption during the history-taking.
- Make sure the survivor feels comfortable. Use a calm tone. If culturally appropriate, maintain eye contact. Be aware of the survivor’s body language and your own.
- Be systematic. Proceed at the survivor’s own pace. Be thorough, but don’t force the survivor.
- Let the survivor tell their story the way they want to. Document the incident in the survivor’s own words.
- Avoid questions that suggest blame (e.g., What were you doing there alone?).
- Be compassionate and non-judgmental.
- Explain what you are going to do at every step.

### Collecting forensic evidence
The main purpose of the examination of a rape survivor is to determine what medical care should be provided. If applicable, forensic evidence may also be collected to help the survivor pursue legal redress.

The survivor may choose not to have evidence collected. Respect their choice. Forensic evidence can be collected only if:
- Timing is appropriate (e.g., less than 72 hours or more than 72 hours in contexts where the local law accepts evidence from more than 72 hours);
- Samples can be analysed in the local context;
- Informed consent is obtained; and,
- The chain of evidence can be maintained.

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

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

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

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Within hours</th>
<th>72 hours</th>
<th>120 hours</th>
<th>After hours</th>
</tr>
</thead>
</table>

*Standard Operating Procedures for GBV Prevention and Response – Nigeria*
### Prevent sexually transmitted infections (STIs) (gonorrhea, chlamydia, syphilis)
- Yes
- Yes
- Yes

### Prevent HIV transmission (post-exposure prophylaxis)
- Yes
- No
- No

### Prevent pregnancy (emergency contraception pill)
- Yes
- Yes
- No

### Care for injuries, wounds
- Yes
- Yes
- Yes

### Prevent tetanus
- Yes
- Yes
- Yes

### Prevent Hepatitis B
- Yes
- Yes
- Yes

### Provide mental health care/psychosocial support
- Yes
- Yes
- Yes

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**Psychological first aid and counselling**
- All survivors of GBV should be offered psychological support.
- Be aware that emotional reactions of survivors in response to GBV are very personal.
- In caring for survivors of GBV, it’s important to be attentive to signs/manifestations of psychological distress/disorder - look, listen, and link.
- In assessing psychological support needed, identify: protective factors and risk factors
- Negative and positive coping mechanisms
- Counselling must take place from the first contact with the patient, including counselling for specific issues such as pregnancy and STIs.
- Tell the survivor they can return to the health service at any time if they have questions or other health problems.

**Medical certificates**

Medical care of a survivor of rape includes preparing a medical certificate. It is the responsibility of the health care provider who examines the survivor to make sure the certificate is completed.

Only the survivor has the right to decide whether and when to use this document.

**Follow up care**

All survivors of GBV will benefit from follow-up medical and psychological care. With the unstable situation, it is possible the survivor will not or cannot return for follow-up. Therefore provide maximum input during the first visit, as it may be the only visit.

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**Important to Note:**

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

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

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

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

**Special considerations for child survivors**

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

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

**Special considerations for male survivors**

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

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

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

**MENTAL HEALTH AND PSYCHO-SOCIAL SUPPORT SERVICES**

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

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

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

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

- Be familiar with the guiding principles and be able to put them into practice;
- Be familiar with GBV core concepts and definitions; and,
- Assess immediate safety and security risks of the survivor.

Figure 5: shows the four levels of MHPSS care for GBV survivors linked to the survivor’s mental state and the care provider.

The Figure above shows the importance of ensuring, firstly, that the basic services and security needs of GBV survivors are addressed. Then, from the perspective of MHPSS, the most appropriate support for GBV survivors is generally

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

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family and community-based interventions by non-specialized actors to support survivors when they are distressed. Some GBV survivors require more specialized psychosocial support, and some may need clinical care.

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

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

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

**Level 4: Clinical care of mental disorders.** Provided by trained local health workers, and international medical organizations. This support is intended for survivors with mental disorders such as post-traumatic stress disorders. It seeks to respond to severe behavioural and emotional disorders, including psychoses. It can include the prescription of psychiatric drugs, as well as a combination of biological, social and psychological interventions.

**SAFETY AND SECURITY OPTIONS**

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

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

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

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

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8 It is important to make the distinction between distress and disorder. Survivors with a disorder will most likely not be able to cope on their own. They will need specialized professional help (e.g., mental health evaluation and treatment). Survivors suffering from distress or extreme distress will also benefit from emotional and social support, although they may also be able to rely on their own coping mechanisms and capacities.
• Find strategies that enable the survivor to stay safely with their family when appropriate (e.g., helping the survivor find a resourceful and trustful family member).
• Identify temporary shelter for the survivor (i.e., a safe, secure and accessible place where they can rest temporarily) with the survivor’s family members or in other nearby and accessible locations.
• Provide financial support and transport to the safe location whenever possible.
• Involve non-offending caregivers in the healing process, especially when the aggressor is one of the parents of a child GBV survivor.
• Ensure more frequent and regular follow-up on cases where the survivor is particularly at risk if no alternative relocation solutions could be found.
• For cases at risk of repeat or escalating domestic violence, help the survivor establish a safety plan whereby they can identify mechanisms to decrease trigger points that cause or lead to the aggression (e.g., not being at home alone when the husband comes back from home; inviting other family members when discussing important issues). In such cases, be very cautious never to blame the survivor.
• Identify a safe place to meet the GBV survivor for follow-up visits and agree on a trusted person to contact in case the survivor is not reachable.
• Provide GBV survivors with information about the whole healing and referral process highlighting potential consequences and benefits of accessing services.
• Engage other sectors to meet in a timely manner other immediate needs raised by the survivor that may further expose them to harm and violence.
• Train staff involved in GBV case management on how to identify suicidal thoughts in survivors.
• Train and ensure all staff comply with an organization’s security procedures while on duty.
• Ensure your organization has a clear code of conduct and that your staff know it.

LEGAL AND JUSTICE ASSISTANCE

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

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

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

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

With respect to justice assistance, actors should:

• Be aware of the legal and justice context in Borno, Adamawa and Yobe States

9 Including initiatives to domesticate relevant legal provisions

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• Consider the emerging legal systems put in place in the different areas of the BAY States.
• Lay the groundwork for improved access to justice for GBV survivors by putting in place quality health and psychosocial services, and by establishing quality case management and referral systems. These aspects of emergency programming can help facilitate the process for GBV survivors who request legal assistance in the future.
• Inform GBV survivors about procedures, potential consequences and benefits on how they might seek formal justice in the near future (forensic evidence, medical certificate etc.) without making promises that cannot be met.
• Enquire and evaluate whether there are other forms of cultural and informal justice systems the survivor might want to access. While not encouraging traditional informal justice procedures such as mediation, if a survivor decides to access such processes, it is a duty of a case manager to inform the survivor about how such processes work and the associated risks.

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

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

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

Law Enforcement

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

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

Procedures

• Referrals should be made to police and NAPTIP ONLY if the child/guardian or survivor has given her/his informed consent.
• If a survivor chooses to report her/his case to the police/law enforcement officer, the officer at the desk will show the survivor/child and guardian to a private interview room
• A specially trained police/law enforcement officer will take the survivor’s statement and obtain information relevant to investigation of the alleged crime. If there are female police/law enforcement officers available, they should conduct the interview
• Child/survivor does not need to present a medical form before investigation starts
• Police/law enforcement institution should begin to conduct investigation immediately
• When warranted, police arrest alleged assailant, and file charges with the court
In the event the police/law enforcement officer maybe required to accompany the survivor for medical check-up and care, survivor’s dignity should be upheld and should not be taken in the company of the perpetrator.

All law enforcement officers should be aware of GBV guiding principles and existing services for survivors including referral pathways and should facilitate referral of survivors to appropriate services.

**Judicial institutions**

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

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

Legal actors will assess the national/state justice system for child-friendly procedures. In the absence of established procedures, legal actors should introduce and support innovative practices, such as including social worker’s/case workers in sessions in which children are expected to deliver official statements to the police/courts, or advocate that hearings for child survivors should take place in the judge’s chambers, in the presence of social worker’s/case workers.

**Legal Aid and Counselling**

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

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

**Figure 6: Judicial procedures**

<table>
<thead>
<tr>
<th>STAGES</th>
<th>SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
<td>Conduct awareness about services, laws, policies and procedures</td>
</tr>
<tr>
<td>Initial contact</td>
<td>A positive initial contact experience with the justice system is crucial for victims/survivors of violence.</td>
</tr>
<tr>
<td>Investigation</td>
<td>Assessment &amp; investigation should be started in timely fashion, conducted in a professional manner, meet evidentiary and investigative requirements, and all available means to identify and arrest the suspect are exhausted. Throughout, the survivor’s safety, security and dignity are carefully considered and maintained.</td>
</tr>
<tr>
<td>Pre-trial processes</td>
<td>Criminal, civil, family and administrative pre-trial/hearing processes that are non-biased and sensitive to the specific needs of survivors are essential to guaranteeing their right to justice</td>
</tr>
</tbody>
</table>
**Trial processes**

Measures should be in place to prevent further hardship and trauma that may result from attending the trial. Ensure that trial processes maximize the survivor’s cooperation, promote her capacity to exert agency during the trial stage while ensuring that in criminal matters, the burden of seeking justice is on the State.

**Perpetrator accountability + reparations**

Appropriate sanctions to hold perpetrators accountable for their actions and providing for just and effective remedies to the survivors for the harm or loss suffered by them.

**Post-trial processes**

Measures to support healing and rehabilitation

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

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

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

**LONG-TERM ASSISTANCE**

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

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

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

- Helping the survivor liaise with organizations providing long-term activities and opportunities to help them fully reintegrate into their communities, empower them and give them tools to protect themselves in the future.
- Referrals to organizations offering age-tailored vocational and skill-training opportunities, formal and non-formal educational programmes, safe income-generating activities, livelihood activities and cash assistance. Provision of cash assistance should be tailored to the survivor’s needs, should adhere to do no harm principle and should follow international guidance.
- Referrals to families and communities as part of promoting resilience. Community reintegration is an essential part of a survivor’s recovery process, for adults as well as children. In the areas where these SOPs apply, GBV case management actors will find it essential to support survivors to reintegrate with families and communities for ongoing support because availability and access to ongoing services for survivors are extremely limited. These kinds of referrals are more informal. They must be guided by the survivor who will decide what and if to disclose information to anyone. This type of referral requires special attention to confidentiality.

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

It is clear the benefits of creating opportunities for women and girls are wide-ranging and transformational; for women and girls to have the opportunity to fulfil their potential, for their children, for their communities. However, in order for

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10 IRC, Mercy Corps, Women’s Refugee Commission, Toolkit for Optimizing Cash-based Interventions for Protection from Gender-based Violence: Mainstreaming GBV Considerations in CBIs and Utilizing Cash in GBV Response, 2018
women and girls to be able to access these opportunities and fully participate in and benefit from interventions, it is essential we confront the biggest obstacle to their health, education, economic status and overall well-being: violence.

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

**Skills Building, Livelihoods and Education**

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

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

**Can cash be utilized in GBV response?**

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

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

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

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

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

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

Child survivors

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

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

- The best interests of the child should always be prioritized.
- Communication with child survivors should use child-friendly techniques to encourage them to express themselves.
- If the child survivor wishes, s/he can privately talk with a social worker or counsellor.
- Where both child protection and GBV actors are available, child survivors should be referred to GBV case workers for specialised care and to child protection actors for other components of child protection case management. Both GBV and Child Protection Case workers should work collaborate in the best interest of the child. Both child protection and GBV actors should be trained on how to care for child survivors – both boys and girls.
- After the initial assessment provided, referrals should be made to specific organizations skilled in working with child survivors.
- The parents or caregiver of the child and the child should always be informed about the next steps and available services, and about risks and benefits of accessing them.
- If the case manager and caregiver are unable to come to an agreement about the provision of services, and if it is the case manager’s opinion that the caregiver is not acting in support of the child’s best interest, the service providing organization may need to intervene.
- Action needs to be taken if there are suspicions the perpetrator is a family or household member or the caregiver is in disagreement with the services providers.

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

12 See GBV Case Management SOPs for Nigeria
- For children under the age of 14, when parents and/or caregivers are suspected to be perpetrators or complicit in children’s abuse, involving an adult that the child trusts, such as a relative, should be prioritized. The child should be supported to identify an adult whom they trust. It is acceptable to proceed with only the child’s permission only in cases when the life and/or safety of the child is at risk and therefore immediate support is needed. In such circumstance, the following guidelines also apply:
  - Service providers should follow a decision-making process that first considers the child’s safety and best interest of the child.
  - Supervisors and specialists within the GBV Sub-Sector should be consulted in the decision-making to determine the best course of action when possible.
  - Where it is not possible to consult specialists, specific safety measures should be taken, relevant to the context, and regular follow up might be required.
  - Consideration can be made for the family to be referred to family wellbeing activities and/or women centre programmes and/or child friendly spaces in the area if available.

**Adolescent girls**

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

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

- Assess the safety of the survivor, including how easy it is for the perpetrator to have access to her and what support she might expect from her family.
- Recognize that she may be feeling confused, guilty, scared and sad. Her emotional state may affect what she is willing to disclose and to whom she is willing to talk.
- Recognize that she may not understand what has happened to her, and she may not be aware of the possible consequences of sexual violence including pregnancy and STIs.
- Use simple language to explain what services are available, including the possible consequences of accessing these services.
- Pay attention to the development stage of the girl. The ability of a survivor to explain what has happened and to make decisions about services she wishes to access can differ greatly depending on her age and level of education.

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

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

**Figure 7: Summary of Case management response for child marriage**

<table>
<thead>
<tr>
<th>FOR IMMINENT RISK CASES</th>
<th>FOR GIRLS WHO ARE ALREADY MARRIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get consent to work with the girl.</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Assess: How does she feel about the marriage?</th>
<th>Assess her needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide information to the girl about the consequences of marriage.</td>
<td></td>
</tr>
<tr>
<td>Identify with her a supportive family member or other trusted adult.</td>
<td>Provide information about the services available and make referrals.</td>
</tr>
<tr>
<td>With the girl’s consent, engage the supportive family member or other trusted adult.</td>
<td>Carry out safety planning.</td>
</tr>
</tbody>
</table>

If person identified is parent or caregiver.
Discuss pro and cons of child marriage.
Provide information to the identified persons on the consequences of child marriage.

If person identified is not parent or caregiver.
If safe to do so and with the girl’s consent, support the identified person to have a conversation with the decision-maker in the family.

If marriage is likely to go forward, focus on risk reduction.
Assess the girl’s concerns and questions, and potential risks related to her safety and health.
Carry out safety planning.
Provide information about services and referrals.
Help her identify a supportive person in her life.
Help her identify positive coping strategies.
With her consent, engage—or continue to engage—a supportive adult.

While child marriage is not a new phenomenon in NE Nigeria, the specific nature of the conflict and humanitarian interventions has contributed to this practice. This therefore requires system wide efforts to support meaningful prevention and risk mitigation interventions. The Gender Based Violence and Child Protection Sub Sectors consistently advocate for a concerted effort from agencies/sectors given the interconnectedness of the issues in order to prevent and mitigate risks associated with provision of aid\(^{13}\).

**People with disabilities**

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

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

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

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\(^{13}\) See GBV-CP SS Briefing Note: Inter-Agency Efforts Needed to Avert Child, Early and Forced marriages

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

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

**Older Women**

Research studies\(^{14}\) demonstrate how aging is not a factor that protects women from GBV, especially in displacement situations. Older women undergo multiple forms of discriminations, on the basis of gender and age. Age-specific factors, such as physical vulnerability, displacement, possible illness, isolation, dementia, lack of social connections or dependence on relatives or neighbours, put older women at greater risk of violence compared with women of younger age. Older women who experience violence are more likely to have severe consequences such as fear, anger, depression, exacerbation of existing illness, confusion, severe psychosocial distress and life-threatening injuries. Further, they are especially vulnerable to economic abuse, in particular, they experience obstacles as they attempt to secure inheritance and property rights, and face greater challenges in accessing information on available services. Older women could also internalize and normalize abuse and violence with the time, or not recognize abusive behaviour like domestic violence.

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

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

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

**Male survivors (Men and boys)**

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

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\(^{14}\) AAAS Scientific Responsibility, Human Rights and Law Program, Age is no protection: Prevalence of gender based violence among men and women over 49 years of age in five situations of protracted displacement, July 2017
Many male survivors of sexual violence do not report the incident because of extreme shame. Many face additional barriers to accessing care because traditional notions of normative masculinity do not promote self-care and healing as practices for men. Instead, male survivors may turn to negative coping mechanisms (e.g., drug and alcohol abuse).

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

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

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

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

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

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

GBV Assessments and Research

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

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

Figure 8: Ethical and safety recommendations that apply when collecting information about sexual violence

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

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

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

- A place where women and girls have easy access, privacy and feel safe.
- A place where women and girls can obtain information about available services, including gender-based violence (GBV) services and receive support (either through WGFS or through referrals).
- Reduce emotional distress, through psychosocial support, recreational activities and peer support.
- Provide information on issues relevant to the lives of women and girls.
- Connect women and girls to other services (such as livelihoods or medical services).
- Develop or strengthen women’s and girls’ social networks, build relationships and create opportunities for experience sharing.
- Empower women and girls so they are able to identify solutions and strategies to address concerns and to act and advocate for themselves.

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

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

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

WGFS aim to create an empowering and inclusive environment where women and girls attending feel safe, supported, connected, empowered and better informed about their rights and opportunities. Therefore, the creation of WGFS in Borno, Adamawa and Yobe States should follow the six guiding principles for establishing WGFS:

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

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

**Dignity kits**

The GBV SS supports the use of standardised dignity kits in the context of GBV programming in north east Nigeria to help women and girls maintain their dignity during the humanitarian crisis. Standardised dignity kit package and guidance note developed by the GBV SS: provides what is considered from community consultations as relevant, with the appropriate content that meets the basic minimum dignity of women and girls of reproductive age.

In January 2019, the Humanitarian Country Team (HCT) made bold commitments on the addressing critical gaps in dignity and menstrual hygiene needs of women and girls affected by displacement in the north east. The HCT outlined the following six critical areas:

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

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

Organizations that are planning to distribute dignity kits should:

- Follow and respect the standardised dignity kit package and guidance note
- Liaise with the GBV SS’s Technical Working Group on Dignity Kits to coordinate the location and target population;
- Coordinate with other actors covering the same areas to avoid duplication of materials;
- Prioritize the use of dignity kits that are procured and assembled locally;
- Distribute the dignity kits at regular intervals throughout an emergency; and,
- Consider the needs of women and girls of reproductive age that have been displaced and IDPs as beneficiaries.

**For other humanitarian sectors**

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

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15 The GBV SS Dignity Kits Guidance Note, 2019
The responsibility for preventing and mitigating the risks of GBV is a shared one amongst all humanitarian actors. Addressing GBV is considered life-saving and meets multiple humanitarian donor guidelines and criteria. In spite of this, GBV prevention, mitigation and response are rarely prioritized from the outset of an emergency.

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

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

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

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

**Protection from Sexual Exploitation and Abuse (PSEA)**

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

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

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

Policies and practices for PSEA should cover:

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

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

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

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

CLOSURE OF GBV PROGRAMMES

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

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

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

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

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

DOCUMENTATION, DATA, AND MONITORING

Safe and ethical sharing of GBV related information is critical. Some challenges related to sharing of GBV information include; safety concerns for the survivor, family and those involved in responding, questions around confidentiality and

17 See Standardized dignity kits

Standard Operating Procedures for GBV Prevention and Response - Nigeria
consent, misinterpretation of data (i.e., reported incidents), tensions among partners (due to sharing or not sharing), strained working relationships, among others. Three general categories of GBV information include

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

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

3. Other information re. GBV risks/trends: Mostly qualitative information, often from existing sources (FGDs, community feedback mechanisms, programme. monitoring, etc.), useful for programming, advocacy, coordination, donor reports, sitreps, etc. Can be analysed alongside other quantitative data from respective sectors.

Documentation of GBV incident when appropriate, by persons with the relevant skills (See GBVIMS) provides critical summary of the most relevant information about an individual GBV incident, if not the case history. Collecting relevant data about each GBV case and gathering them in a database will a) generate data for monitoring and evaluating GBV cases progress, b) offer a clear view on the disclosed cases in a specific area, and c) help to evaluate the functioning of multi-sectoral response to GBV.

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

The GBV IMS coordination point at UNFPA compiles monthly incident reports for Borno, Adamawa and Yobe and quarterly narrative trend analysis. Monthly incident reports are only available for data gathering organisations as per specific Information Sharing Protocols, while the monthly statistics and quarterly narrative trend analysis is available externally.

Data Management Protocols

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

Data protection

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

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

- All staff in contact with the data have a strong understanding of the sensitive nature of the data, and the importance of data confidentiality and security.
- Staff have been asked to identify security risks specific to their context and to think through the possible implications for clients, their families and communities, and for the organization, if data gets into the wrong hands.
• Clients and/or their caregivers need to give informed consent to gather and store their data before any information is recorded.
• Staff are aware that when obtaining informed consent, clients may highlight particular information they do not want shared with certain people, and that this must be recorded and respected.
• Signed paper consent forms must be kept in a locked filing cabinet.
• Information must not be passed on to a third party without the informed consent of clients and/or their caregiver(s).
• Staff who are working with GBV data are aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.
• Staff who work with GBV data have signed a data protection agreement.

Information sharing

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

• Information about specific incidents of GBV should not be shared.
• Special care should be taken when distributing information.
• All guiding principles associated with ethical and safe information collection must be upheld.
• No identifying information should be included in any of the data summaries.
• Information that is private, which could identify individuals or particular communities, or that could endanger members of the affected population or staff members, should not be disclosed publicly.

Information that should be shared includes:

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

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

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

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

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

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

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

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

The Gender-Based Violence Sub Sector- Nigeria is the forum for coordination and collaboration on GBV prevention and response in Nigeria’s humanitarian response. It brings together NGOs, UN agencies, civil society organisations, and relevant government institutions under the shared objective of ensuring life-saving, predictable, accountable and effective GBV prevention, risk mitigation and response in emergencies.

The Ministry of Women Affairs and Social Development is the chair and United Nations Population Fund (UNFPA) is the sector lead Agency of the GBV SS since its inception in 2015. A Strategic Advisory Group – comprising UN, INGO, Government and Civil Society representatives (Women Led Organisations) - provide overall guidance and strategic orientation to the sub sector. The operational coordination of the GBV SS is from Maiduguri, Borno State with sub working groups in Adamawa and Yobe States. At LGA and/or Camp level, organisations volunteer to lead GBV field coordination with guidance from the Secretariat in Maiduguri. The Strategic Advisory Group (SAG) provides support and guidance for the strategic direction and technical advisory on key issues related to GBV protection and response to partners, sectors and the HCT. The SAG is responsible for leadership accountability for GBV commitments and monitors the implementation of the GBV SS strategic framework and annual response plan.

The GBV SS meets monthly in Borno, Adamawa and Yobe States. Information – both strategic and operational is shared at least monthly between members of the GBV SS. At field level (LGA/Camp) Field Focal Points organise monthly and/or bi-weekly meeting depending in the context, sometimes jointly with protection actors or separately as GBV actors. Case conferencing is convened on need basis and chaired by a GBV case management actor. This information and discussions guides the continuous development of response interventions.

Membership is free and open to all humanitarian organizations involved in GBV prevention and response under the goal of reducing risks and mitigating consequences of GBV experienced by women, girls, boys and men in north east Nigeria. This includes UN agencies, international and national NGOs and international organizations. Organizations are encouraged to be represented by technical staff in GBV and women's empowerment. All potential GBV SS partners are expected to fill an online form to provide baseline information on their services and affirm their commitment to the guiding principles.

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

COMMUNICATIONS: INFORMING SERVICE PROVIDERS ABOUT THESE SOPs

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

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

- Where to go for help at different levels (i.e., referral pathways).
- What to expect in terms of roles and responsibilities of different humanitarian actors.
- Limitations and risks in accessing services.

See Gender Based Violence Sub Sector – Nigeria Terms of Reference for more information

• Guidelines on confidentiality after disclosure.
• GBV Guiding Principles.

Target groups within communities for this communications include:

• Service providers
• Humanitarian actors
• Camp management
• Local leadership structures
• Women’s networks
• Teachers
• Religious leaders

GBV Sub Sector partners agree to:

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

CONFIDENTIAL Form: Consent for Release of Information

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

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

1.

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

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

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

I would like information released to the following:

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

YES NO

☐ ☐ Safe shelter/house (Specify)

___________________________________________________________________________

YES NO

☐ ☐ Psychosocial Support Services (Specify)

___________________________________________________________________________

YES NO

☐ ☐ Health/Medical Services (Specify)

___________________________________________________________________________

YES NO

☐ ☐ Law Enforcement/Security Services (Specify)

___________________________________________________________________________

YES NO

☐ ☐ Legal Assistance Services (Specify)

___________________________________________________________________________
YES  NO
☐  ☐  Livelihood Services (Specify)
_________________________________________________________

YES  NO
☐  ☐  Other (Specify type of service, name and agency)
_________________________________________________________

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

2.
I have been informed and understand that some non-identifiable information may also be shared for reporting. Any information shared will not be specific to me or the incident. There will be no way for someone to identify me based on the information that is shared. I understand that shared information will be treated with confidentiality and respect.

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

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

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

Client’s Name: __________________________________________________________

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

Contact Number: _______________________________________________________

Address: _______________________________________________________________
GUIDANCE FOR RECEIVING, RECORDING & REFERRALS

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

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

PLEASE NOTE THIS INFORMATION SHOULD BE KEPT CONFIDENTIAL
## Inter-Agency SEA Complaint Intake and Referral Form

<table>
<thead>
<tr>
<th>Name of Complainant:</th>
<th>Nationality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/Contact Details:</td>
<td>Position/Identity Number:</td>
</tr>
<tr>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>How does complainant prefer to be contacted? (Give details)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of victim/survivor (if not the complainant):</th>
<th>Nationality:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address/Contact Details:</td>
<td>Identity No.</td>
</tr>
<tr>
<td>Age:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Name(s) &amp; address of parents/legal guardian, if under 18:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has survivor given consent for completion of this form?</th>
<th>YES:</th>
<th>NO:</th>
<th>I DON’T KNOW:</th>
</tr>
</thead>
</table>

| Is the victim/survivor receiving any type of humanitarian assistance? (Name the organisation/agency providing assistance): |

<table>
<thead>
<tr>
<th>Date of incident(s):</th>
<th>Time of incident(s):</th>
<th>Location of incident(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief description of incident(s) in the words of the survivor / complainant:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Briefly describe service(s) provided to survivor:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the perpetrator a continuing threat to the safety of the survivor, complainant, staff or any beneficiary? Please explain any safety concerns:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of accused person(s):</th>
<th>Position / Job title of person(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency accused person(s) works for:</td>
<td></td>
</tr>
<tr>
<td>Address or location where accused person(s) works:</td>
<td></td>
</tr>
</tbody>
</table>

**Agency receiving complaint:**

<table>
<thead>
<tr>
<th>Name of person completing form:</th>
<th>Position / Job title:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

**Referral to Agency of Concern PSEA Focal Point**

<table>
<thead>
<tr>
<th>Name of agency / name of person (PSEA Focal Point) report forwarded to:</th>
<th>Date of referral:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and position of person report forwarded to:</td>
<td></td>
</tr>
</tbody>
</table>

**Acknowledgment of receipt**

<table>
<thead>
<tr>
<th>Name &amp; Position / Job title:</th>
<th>Agency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>Date received:</td>
</tr>
</tbody>
</table>

Send Completed form to the following confidential email address: nga.psea@humanitarianresponse.info
### Annex III: Inter-Agency Referral Form for survivors of GBV

<table>
<thead>
<tr>
<th>Priority:</th>
<th>Referred via:</th>
<th>Referral Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High (Follow up requested within 24 hours)</td>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Medium (Follow up within 3 days)</td>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Low (Follow up within weeks)</td>
<td>In Person:</td>
<td></td>
</tr>
</tbody>
</table>

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

#### Referred By:
- **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)

- **Name/Survivor Code:**
- **Address:**
- **Phone:**
- **DOB:**
- **Sex:**
- **Displacement status:**
- **Language:**

#### Background Information/Reason for Referral:
(problem description, duration, frequency, etc. only relevant for the referral)

- **Name of primary caregiver:**
- **Contact information for caregiver:**

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

<table>
<thead>
<tr>
<th>Agency</th>
<th>Support</th>
<th>Date (incl. ongoing)</th>
</tr>
</thead>
</table>

#### Services Requested:

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

**Provide additional explanation here:**

#### ADDITIONAL SPECIFIC NEEDS of the SURVIVOR
### Child
- Child not attending school
- Teenage Pregnancy
- Child spouse
- Child mother
- Child engaged in worst form of child labour
- Child formerly associated with armed forces/armed groups
- Unaccompanied/separated child
- Child living with disability

### Woman
- Pregnant
- Woman head of household
- Woman living with disability

---

**IMPORTANT**

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

---

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

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

Signature of Responsible Party: __________________________ Date: ____________

**Details of Referral:**

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

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

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

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

---

**Receiving Organization:**

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

---

*Standard Operating Procedures for GBV Prevention and Response – Nigeria*
Annex IV: Referral Guide for Gender Based Violence - Nigeria

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

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

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

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

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

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

SURVIVOR MAY REFER HERSELF/HIMSELF TO ANY SERVICE PROVIDER IF THE SURVIVOR HAS GIVEN INFORMED CONSENT FOR REFERRAL

IF THE SURVIVOR HAS GIVEN INFORMED CONSENT FOR REFERRAL

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

- Conduct an immediate security and safety needs assessment.
- Create a safety plan that addresses both ongoing risks and the additional risk created by reporting the complaint.
- Conduct follow-up assessments as necessary.

FOR SEXUAL AND/OR PHYSICAL VIOLENCE: Ensure immediate access to HEALTH / MEDICAL CARE SERVICES (within 30 Days/72 Hours to reduce the risk of HIV and 5 days, or 120 Hours to reduce the risk of unwanted pregnancy)

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

GBV Case Management; Mental Health and Psychosocial Support

- Counselling, Psychosocial support and critical steps in GBV case management and advocacy to assist survivors in accessing needed services; support and assistance with social re-integration
- Where there is a GBV Case Management Agency, refer to them to assist recovery process.

If the survivor wants to pursue Legal Action

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

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

GUIDELINES FOR RESPONDERS

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

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

The survivor may refer herself/himself to any service provider

FOR SEXUAL AND/OR PHYSICAL VIOLENCE: Ensure immediate access to HEALTH / MEDICAL CARE SERVICES (within 30 Days/72 Hours to reduce the risk of HIV and 5 days, or 120 Hours to reduce the risk of unwanted pregnancy)
Annex V: Nigeria: Inter-Agency Sexual Exploitation and Abuse (SEA) Complaints Referral System

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

**Entry points for reporting include, but not limited to the following:**
- Toll Free helplines/hotlines, Complaints and feedback boxes in camps and communities,
- Confidential email
- Women and Girls Friendly Spaces (WGFS); Child Friendly Spaces (CFS), adolescent/youth friendly spaces, school and learning centres,
- Health centres/facilities, Protection complaint desks; distribution sites,

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

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

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

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

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

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

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

Complaint implicates a security actor: For Nigeria Police Force (NPF) Call PCU – 08057000001, 08057000002; SMS and WhatsApp: 08057000003;
For Nigeria Security & Civil Defence Corps: Call PCR 08033941284, 08033941284
For military, CJTF or Gov’t Official refer to nga.psea@humanitarianresponse.info

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

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

Standard Operating Procedures for GBV Prevention and Response – Nigeria
Annex VI: Nigeria: Standardised Dignity Kit Package

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

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

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

This content may vary over time according to the needs and feedback of the affected population. The GBV subsector will review the contents of the kits based on post-distribution monitoring conducted by organizations every 6 months (the estimated life of the standard kit in an emergency phase), with the first review of contents beginning with the NHF 2019 Reserve Allocation 1.

\textsuperscript{22} For locations where assessment has found that women and girls prefer disposable pads for various reasons, the minimum quality should be at least 2 packs per month
Remember that:

- Also within one group, different professionals can have different responsibilities (e.g. a protection officer of an NGO has not the same responsibility as a police officer or a lawyer, a nurse has not the same tasks as a doctor…)
- Some tasks and responsibilities may overlap.

The Health Group:

- Ask detailed questions about what happened during the incident
- Ask detailed questions about injuries
- Conduct a medical examination of a 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

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 (clothes, food…)*
- Facilitate access to income-generating activities for survivors*
- Ensure that existing clinical mental health services can deal with disorders resulting from sexual violence
- Work with the community to reduce stigma and discrimination against survivors of sexual violence and to mobilize the community to support and protect survivors from further harm

The Protection/Safety/Security Group:

- Take detailed statements from survivors, establish facts
- Investigate cases of sexual violence
- Ensure same-sex police officer conducting interviews of survivors or provide a choice to the survivor of the sex of the police officer
- Arrest perpetrators of sexual violence
- File charges with the court
- Identify relevant national laws and policies regarding sexual violence
- Identify traditional systems in the community for protection, problem-solving and/or justice
• Identify high-risk areas in the setting, e.g. where sexual violence incidents occur, where women and girls perceive safety and security risks, etc.
• Establish strategies for improving security to prevent incidents and to protect survivors who want to report incidents.
• Provide information about legal and judicial remedies to survivors
• Provide shelter to survivors
• Share de-identified data about sexual violence cases with other sectors

The Legal Justice Group:

• Provide information about legal justice mechanisms to survivors
• Provide legal counselling and representation to survivors
• Monitor court cases
• Assist survivors in bringing their case to court
• Take detailed statements from a survivor; establish facts
• File charges with the court
• Apply the relevant national laws regarding sexual violence
• Inform survivors about their rights and possibilities for legal action

Roles and goals of everyone dealing with survivors of sexual violence:

• Consider the safety of the survivor
• Provide information about support options to the survivor and manage expectations
• Ensure referral to the appropriate services
• Treat the survivor with dignity, ensure confidentiality
• Show sensitivity, understanding and willingness to listen to the concerns and, if appropriate, the story of the survivor
• Coordinate support with other sectors

Adapted from, UNICEF; Caring for Survivors - General and Psychosocial Module Handouts for Participants
Annex VIII: Criteria: Minimum Requirements to be Part of the GBV Referral Pathway

All criteria listed here constitute the minimum requirement a service provider must have to be part of the referral pathways. Compliance with all criteria will be mandatory and a prerequisite to be part of the referral pathways.

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>MINIMUM REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PRESENCE</td>
<td>To be part of the referral pathway, organizations are required to have operational presence in one of the HRP states – Borno, Adamawa and Yobe, 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.</td>
</tr>
<tr>
<td>2 LEGAL STATUS</td>
<td>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.</td>
</tr>
<tr>
<td>3 ADHERANCE TO HUMANITARIAN PRINCIPLES</td>
<td>To be part of the referral pathway, an organization (and its implementing partners) must have a Code of Conduct and PSEA policy in place.</td>
</tr>
</tbody>
</table>
| 4 COMMITMENT                      | Senior 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 SERVICE DELIVERY                | 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 CAPACITIES                      | 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.                                                                                   |
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>60</td>
<td>When GBV guiding principles cannot be guaranteed due to the lack of capacities, organizations should not deliver GBV response services.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td><strong>HUMAN RESOURCES</strong></td>
<td>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.</td>
</tr>
<tr>
<td>9</td>
<td><strong>MINIMUM STANDARDS</strong></td>
<td>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.</td>
</tr>
<tr>
<td>10</td>
<td><strong>KNOWLEDGE</strong></td>
<td>GBV services providers should have been trained in their areas of expertise and be professionally prepared to deal with GBV survivors.</td>
</tr>
</tbody>
</table>