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| [COUNTRY NAME] |

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| Secondary Data Review |  |  |
| **MONTH YYYY** |  |  |

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# KEY SUMMARY [1 PAGE LIMIT]

## OVERVIEW

Provide a brief overview of the humanitarian situation. This need not go into great historical detail but should give the reader an idea of overall context, root causes, and underlying risk factors for the occurences of GBV in Emergencies.

## URGENT ACTIONS AND PRIORITIES

Give a short summary of the results of the Secondary Data Review listed in more detail below. Make sure you list first: the key priorities and/or actions (what have you found in secondary data that makes you believe these are the most critical areas for intervention. These should be short, succinct and also be as actionable as possible, including specific geographic locations and/or target groups for prioritization. Create intersectoral links where necessary), the key geographic areas (were there any areas where secondary data shows the situation was worse than others e.g. north of the camp vs. south, governorate X vs. Y, etc.), and the key vulnerable groups (were any groups particularly affected? E.g. Women over 60 years old, girls with disabilities, or women from minority group X). As such, this section might focus on the following:

* Key priorities
* Key GBV types
* Key GBV risks factors
* Key geographic areas
* Key vulnerable groups

If available, include snapshots of any PINs and/or severity estimates to visualize the GBV situation for the reader.

# CONTEXT and Gender dimensions [1-2 PAGES MAXIMUM]

## INSTITUTIONAL and security ENVIRONMENT

### Legal system and justice

What is the legal system like? Here are some questions that might help in gathering information for this section:

* Rule of law: What is the general rule of law in the context? Does the country ratify CEDAW? Are institutions still functioning or has rule of law completely eroded due to the crisis? What are some of the customary law or practices being implemented by communities and how? E.g. is the judiciary still functioning, are any authorities in place, etc. Describe how this impacts women and girls’ in relation to GBV. Keep in mind these laws are at a national level and may not be practiced at community level.
* Laws and policies related to GBV - e.g. mandatory reporting, religious court, marital laws, criminal laws regarding GBV/in-marraige physical/sexual violence e.g. Criminalization of GBV (what laws exist regarding GBV? e.g. rape by intimate partner criminalized or considered a family affair? Acts of GBV considered criminal acts? Laws related to abortion (is abortion legal? Under what circumstances?)
* Family laws- what type of marriage is allowed, what are rights to divorce, custody, inheritance; adultery outside of marriage, abortion, etc);
* Justice - Access to justice (police, standing in court, survivor-centered appraoched in justice e.g. does a rape survivor need to marry her perpetrator); Are there survivor-centered approaches in justice e.g. does a rape survivor need to marry her perpetrator?),
* Women's rights: what laws are in place to protect women and girls, or which laws in place do the opposite. What are the rights of women in this context? Describe general laws that exist that regulate the life of women and girls - access to information, civil liberties and rights (political participation, freedom of expression, documentation, access to productive and financial resources (Housing Land Properties, employment, work rights, etc).
* Definition of sexual violence/rape: How (if any) is sexual violence and rape defined by law? Is intermarital rape considered a criminal act? What are the repercussions for rape and sexual violence? Are sentences to those convicted of a criminal act survivor-centered or not (e.g. a woman has to marry her rapist)? How many cases that come to court end in a conviction?
* Marriage laws: What are laws regulating marriage or family life that may pose discrimination to women? Is divorce allowed for women? What happens to women when their spouse passes away?
* Housing, land, and property rights: Are women allowed to inherit, either through their families or when their spouse passes away? Are women allowed to have possessions registered in their name, including financial accounts? Do women have rights regarding housing land and property – how does this affect them? Can they inherit any housing, land, property?
* Documentation: Do women and girls have rights to documentation? Is documentation widespread? If documentation is lacking, how does it hamper women and girls?

### Security and social protection

* Access to justice: what legal and judicial framework is there for women and girls to access legal services, press charges; Should a woman want to access justice, is she able to? Is it dangerous for women to access justice? Describe any obstacles to accessing justice and how this impacts women and girls, their rights, and their safety.
* Standing in court: What is the standing of women and girls in court – can they be a claimant in court? Are they likely to be treated with respect when stepping to authorities? What evidence are women and girls required to provide when standing in court and what are the mechanisms to obtain this?
* Overall security situation of the society, policing, community protection mechanisms, social protection mechanisms for women's safety and security.
  + Access to police: What are women and girls’ options for accessing police or other executive bodies? Will women and girls be heard at a police station or are they likely to be turned away? Is it dangerous for women and girls to report at a police station? Will women and girls be forced to reenact when reporting to the police?

### Health Systems

* Introductory paragraph summing up the health system in contexts. Sum up the existing governmental structures; their availability, accessibility, acceptability, and quality. Sum up the regulations in the healthcare system that are important to GBV.
* What are the existing health infrastructure, key stakeholders for GBV health services, available health services for CMR, referral pathways to health service providers available for GBV survivors?
* What are the challenges in the existing health system around accessing health services for GBV survivors (e.g., movement limitation, RH commodities, CMR services available, etc)
* This session should briefly mention information about CMR taskforce, and CMR protocols, if there are health care providers trained on WHO guidance on IPV and CMR (organisations, sex and numbers trained), availability of CMR services, barriers for medico-legal evidence for rape and sexual assault, etc.

### Demographic profile (SADD)

Provide details on the sex, age, and disability disaggregation of the population(s) in question. Look at different age groups (e.g. young girls, adolescent girls, older women) and apply this lens on all the information throughout the SDR. This includes:

* Listing main characteristics of population groups, ensure GBV lens where necessary.
* Migration background, ethnicity, religious affiliation: Describe different population groups e.g. refugees (mixed contexts), IDPs, migrants, host community, migrants, ethnic minorities, etc.
* Household characteristics (size, composition, etc), marital status of the population.

### Economy

* Include relevant information about overall economy, the economic factors that enable specific GBV risks and threats (e.g. extreme poverty, higher unemployment, etc)

### Education

* Education levels: Look at indicators related to education (e.g. literacy rates, enrollment rates, etc.) and explain how these figures can give an insight into existing gender inequalities.
* Highlighting any higher needs groups: Describe the group among people in need that may have additional needs, particularly when it comes to the risk of GBV. These can include unaccompanied and separated minors, female-headed households, etc. Look at whether there are high concentrations of these in certain areas (e.g. a high number of female headed households in governorate X) and look at risks associated with this.

## social, CULTURAL AND RELIGIOUS ENVIRONMENT

This section should provide the overarching cultural and religious context for GBV in the specific to consider. This should provide details on how cultural and religious dynamics perpetuate different gender inequalities. Questions to ask include:

### Gender roles and norms

* What roles are typically ascribed to men and women? How does this positively or negatively affect women? How does this impact the GBV situation?
* Division of labor: What are typical divisions of labor between men and women? Are women allowed to work, generally? What type of (paid or unpaid) jobs are women doing? Are any (paid or unpaid) jobs associated with risks of GBV such as fetching water, collecting firewood, etc.? What is the impact of the crisis on the division of labour – has it changed or is it the same? What is the impact of the current crisis on women and girls’ safety in doing these jobs?
* Household decision-making: To what extent do people think women should be engaged in household decision-making? How much are women involved in decision-making at a household level? Are there areas where women have more influence in decision-making (e.g. raising children)? Where is decision-making for women lacking or not possible?
* To what extent do women have a say in finances at a household level? Are women able to have any money and decide on expenditures? How is the household financial expenditure usually structured, distributed and prioritized?
* Women in education: What does the community think about girls accessing education? Are any negative things associated with girls/women pursuing an education? What are some of the barriers for girls to access education?
* Participation: To what extent are women and girls allowed to participate in the public sphere? Are women and girls seen in high public positions, such as in government, the legal system, etc.? Are they seen in community structures such as community decision making bodies? What is the perception of women and girls who are publicly participating?
* Freedom of movement: To what extent are women and girls allowed to move around freely? To what extent do women and girls require permission from a male relative to navigate their daily lives? Are there any other restrictions (e.g. clothing) that apply to women and girls when being seen in public?
* Traditional marriage practices: List any traditional marriage practices that are common at the community level and may impact GBV. This can include the following:
  + Dowry: Is dowry being paid? Does that influence parents’ decisions on marrying off their daughters at a younger age? How does that contribute to gender inequality? Are women integrated into the husband’s family and is that associated with dowry? What decision-making power does she get in that family/who decides over her?
  + Polygamy: Is it practiced? Formally or informally? What is the standing of the multiple wives? Do different wives have different responsibilities, and can they be negatively impacted by this? E.g. the second wife is seen as less important and will receive less food due to food insecurity.
  + Early marriage: Is it common for girls to get married at a very young age, officially or unofficially? Why is this done (e.g. negative coping mechanism, common cultural practice, etc) and what impact does this have on GBV?
* Perception and practice of divorce: What is the perception of divorce in the community? Are women equally allowed to divorce and what is their standing in the community after? If divorce is not allowed but women are left – what is their standing and what support can they draw upon?

### Cultural and religious attitudes and practices

* List any quantitative or qualitative information on how GBV may be perceived in the community. Think of the following questions: What are general perceptions on GBV in the community? Do people think GBV is an issue? What is seen or described as GBV? Is GBV normalized? Is it acceptable or normal for husbands to beat their wives or exude other forms of power over their wives? What statements are made about women and girls in general?
* Can GBV as a topic be discussed? If it is sensitive, how can GBV be discussed? If GBV is not discussable, how does this impact women and girls? Do people believe GBV is a family affair and should only be dealt with privately? Do people think women’s bodies or behavior should be monitored and observed?
* What are attitudes towards GBV survivors? Does the community think it is wrong for women and girls to speak out publicly on topics of GBV? Are there any community-based protection systems? Are there community-based women support groups?

### GBV prevalence

GBV prevalence data is usually under-reported in all settings, it is not faesible to accurately estimate GBV prevalence in humanitarian settings. However, some countries have conducted VAW prevalence survey and it might be helpful to look at the prevalence data when available to explore "what are the most common types of GBV at the population level?".

In some countries, VAW survey provides essential information for GBV response in emergencies by offering insights into the prevelnce, patterns and dynamics of GBV.

# Underlying GBV risk factors [2-3 PAGES]

## GBV THREATS AND VULNERABILITIES

### Sources of threats

Explain the threats that are currently occurring and how these are affecting different population groups and geographic areas. Includes information describing the main actors responsible for the increased risk and/or exposure to GBV, their responsibilities and duties to protect people, and the factors causing or driving the threats.

### Population at risk

Provide information about at risk population groups that are more vulnerable to GBV than other members of the population as they hold less power in society.

Begin with the traditional at-risks groups for GBV (e.g., ethnic minorities, indigenous groups, female headed households, LGBTQ+, people with disabilities, adolescent girls, IDPs etc) and expand this information further by exploring sub-groups ccording to intersectionality wheel, and by adding more context-specific knowledge.

(e.g., minority members (Mahram, widows, divorcee,migrants, afro-descendant girls, women in low pay jobs) (e.g., minority members (Mahram, widows, divorcee,migrants, afro-descendant girls, women in low pay jobs)

### Vulnerable conditions

Vulnerabilities are characteristics or circumstances of an individual or group, or their surrounding physical environment, which diminish ability to anticipate, cope with, resist, or recover from the impact of a threat related to GBV. These characteristics can be demographic, location, exposure, and/or movement related. People differ in their exposure to a threat depending on their social group, gender, ethnicity, age, and other factors.

Types of information to analyze here include:  
Conditions resulted from the shock events that increased affected population's vulnerabilities, such as the level of exposure to environmental threats (proximity to flooding area, active war zone, etc), scope of displacement and related vulnerable conditions for women and girls in displacement(movement restrictions, lack of civil documentations), and the intersectional risks and vulnerabilities associated with different sub-groups, geographic locations in the current crisis.

### Safety perceptions

Briefly mention about the safety concerns of affected population particularly women and girls. If safety audits are carried out, highlight the findings and recommendations from the safety audits. Information about list of locations women and girls feel particularly unsafe or day to day activities that women and girls are scared to do should be also included.

## Access and response SERVICES

How have the existing institutions (i.e. services and systems) been affected by the crisis? The lack of humanitarian access, disruption of systems (social support, security and safety systems) and services comprise great humanitarian needs and intensified GBV risks.

### Humanitarian access

Briefly mention about the operational access to affected geographical areas, mention the barriers and security limitation affecting the humanitarian actors including list of area with full, partial or limited humanitarian access.

### Specialised GBV Services

Provide an AAAQ for GBV services (availability, accessibility, acceptability, quality.) A starting list of questions to contemplate include:

* What GBV services are available? Are these sufficient in quantity and types?
* Are these services physically accessible? Financially? Are there significant administrative and/or bureaucratic hurdles? Are they sensitive to issues like stigmatization? Are the existence of these services communicated in a sensitive and understandable manner to the community?
* Are these services provided in a manner that respects the culture and norms of the communities they serve? Do they ensure confidentiality?
* Is there any data on the quality of these services?

Here are the definitions for AAAQ:

* Availability refers to the existence of services. Are services sufficient in terms of quantity and type? E.g. whether these exist in a geographic area: schools, health facilities, women friendly spaces, etc.  This requires humanitarian actors from all sectors to collectively map out key services in each sector to inform gaps in service provision.
* Accessibility includes the following components for consideration:
  + **Physical accessibility**: Are facilities located with- in a reasonable distance? Is the route to and from the facility safe to travel? Are there other forms of physical barriers, such as armed guards outside the facility?
  + **Financial accessibility**: How is the service funded? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need to access this service? If so, is the fee reasonable/manageable given the economic circumstances/means of those who need this type of care? What other indirect costs are associated with the service (such as transport)?
  + **Bureaucratic/administrative accessibility**: Are there procedural steps that must be completed before accessing certain services? For example, is a particular kind of registration required? Does accessing relevant information require a bank account, internet access, mobile phone, etc.? What level of literacy and/or numeracy is needed? Are the facilities open at times that are convenient given the daily/weekly responsibilities and preferences of women and girls in the community?
  + **Social accessibility**: Do service providers respect non-discrimination in the provision of services? Are certain groups excluded from services because of language barriers? Are there female frontline workers (including translators/interpreters, if necessary)? Are there any risks of stigma related to a person being seeing in/around a certain facility? Are other responsibilities, such as childcare or household chores, affecting certain individuals’ ability to access services?
  + **Information accessibility**: How is information about services communicated to the community? Is dissemination and content of the information accessible to those who need it, for example, in various languages, formats and modalities (i.e. radio, drama, outreach, print etc.)? Are there alternatives to printed information in order to reach members of the community with limited literacy? Is personal information treated confidentially?
* Acceptability Are the services respectful of the culture of individuals, minorities, peoples and communities? Are services designed to respect relevant ethical and professional standards? Do service providers respect confidentiality and informed consent? Are services gender- and age-sensitive? Are there certain characteristics of the service providers (i.e. gender, international versus local staff etc.) that make the community more or less comfortable accessing services? Does the setup of distribution sites and or modality of distributions take into account cultural considerations?
* Quality Do service providers possess the necessary skills and training? Are there adequate supplies (i.e. drugs that are not expired and stored properly) that meet relevant standards? Is the environment appropriate, non-discriminatory, private and confidential as needed? Are the facilities safe and sanitary? Are services provided at an acceptable standard of care in alignment with relevant standards as appropriate? Quality also extends to the way people are treated before, during and after accessing services.

List of essential GBV services include: case management, psycho-social support, clinical management of rape, PEP, hotlines, referral pathways, etc.   
Broader services can also be analyzed here: women and girl safe spaces (WGSS) and their provision of services, community programs for GBV prevention, entry points for survivors to seek help, etc.

### Sectoral Analysis

For each sector, provide information on AAAQ. This section aims to mainstream GBV, looking at how this affects vulnerable groups’ capacities to access critical services. Disasters, conflicts, pre-crisis vulnerabilities, stressed living conditions, lack of resources are all exacerbating factors for the manifestation of GBV and related negative coping mechanisms. Reduced availability and accessibility of basic services (sources of income; health facilities, food, markets etc.) as a result of the *conflict/displacement/natural disaster* increase the vulnerabilities of women and girls. Therefore, all issues related to the availability, functionality, performance or coverage of basic services can be reported under this category.

Here is a list of sample questions for some sectors:

*Food security:**Availability:* What is the food security situation like – how food insecure are people? Are food distributions available? Are they available in the necessary quantity and quality?

*Accessibility:* Are food distributions taking place in a safe and dignified manner? Who controls the food distribution, are there risks of food diversion? Does everyone have access to food distribution points? Are food distribution points safe? What are the conditions at these points, what is the average waiting length to receive food? What’s the condition and average length people have to wait to receive food distribution? Are there any women frontline workers?

Acceptability: Are there risks of sexual harassment or abuse? Are women and children safe after having received food distributions? Are there any factors that would deter women and girls from traveling to the distribution points, i.e. incidents of mugging or robberies or fighting? Who holds the food ration card and do women receive food rations from family members if the cards are not in their name? What are cultural practices? E.g. Do women usually eat last and receive the last scraps or less nutritional food than others?

Quality: Do service providers possess the necessary skills and training?

*Livelihoods:*

Has the current crisis changed anything in the livelihood status of people? Has a lack of livelihoods/income led to an increase in negative coping mechanisms (e.g. survival sex, early marriage); have those increased the risk to GBV?

Do women have access to income generating activities? What type of activities can women do? What restricts their access to other activities? What unpaid work are women and girls engaged in and does that increase the risk to GBV?

Quality: Do service providers possess the necessary skills and training?

*Water, Sanitation, and Hygiene:*

*Availability:* Is there sufficient water? Are sanitation and hygiene services/distributions sufficient and of quality?

*Accessibility:* If women and girls are responsible for fetching water, does that increase their risk to GBV? What are distances to the nearest water points and what are risks on the way there? Is it safe for women/girls/children to access WASH facilities?

*Acceptability*: Do women/girls get harassed on their way to WASH facilities? If women and girls feel unsafe accessing facilities, what are negative coping mechanisms associated with this?

*Quality:* Are facilities built as per Sphere standard, i.e. gender-segregated? Female to male ratio 3:1? Do latrines/WASH blocks have sufficient lighting and locks? Are men loitering around latrines/WASH blocks at night? Is there sufficient privacy in latrines/WASH blocks? Quality: Do service providers possess the necessary skills and training?

*Health:*

*Availability*: Are health services available and functional in the aftermath of the crisis? Are health services being provided through the government or through humanitarian actors? What type of services are available, what is the service coverage and delivery modality, i.e. static facility vs. mobile, only available at district center or municipality etc? Is primary health care available? Do clinical management of rape services exist and are those up to standards? How are they arranged?

*Accessibility*: Is there safe access to health services? Are they available 24/7 or have convenient opening times? Are they expensive? Are there transport fees when accessing? What is the average travel time to a health facility? Can women/girls access services anonymously – and are they likely to do so in this context to seek help?

*Acceptability*: Is there any stigma or gossip attached to seeking out health services? Do women and girls have knowledge on sexual and reproductive health? What is the age of reproduction? Do women and girls know about anti conception and do they have the power to make their own decisions on this? Are there any social norms or customs that deter women and girls from accessing health services (e.g. stigmatization)? Do women and girls need male head of the household permission to seek health services?

*Quality*: Is there trained CMR staff? Enough female staff? Is the facility sensitive to age and sex, so that adolescents, children, both male and female can receive care? Do they discriminate based on ethnicity? Are there sufficient post rape kits and PEP? Is there privacy and private space to treat patients?

*Shelter:*

Availability: Is shelter available? What are the conditions of the shelter and do these conditions increase the risk of GBV? Accessibility: Are shelters private (e.g. with lockable doors/windows)? Is there sufficient lighting around houses? Do women and girls report feeling safe in their shelters? Are shelter distributions accessible, also for female headed households? Are NFIs distributions accessible? What are conditions at distribution points and/or markets? Are women and girls able to access these markets? What are the likely implications for female headed-households? What type of fuel/energy is used? Who is responsible for fetching firewood? What are risks to women/girls in fetching firewood (e.g. on the way, during)?

*Acceptability:* What are the conditions of the shelter and do these conditions increase the risk of GBV? Are shelters safe (e.g. with lockable doors/windows)? Is there sufficient lighting around houses? Do women and girls report feeling safe in their shelters? Depending on shelter types, think about GBV risks that may occur (e.g. sleeping out in the open may increase exposure to GBV and other protection risks).

*Quality:* Quality: Do service providers possess the necessary skills and training?

*CCCM:*

Availability: Are SMS/CCCM services being provided to a high standard? Is there enough space for people (what is the density?

Accessibility: Are there enough safe and accessible pathways in the camp? Are there enough services and if not what effect does that have on GBV? Is there enough lighting in campsites, if not what effect does that have? How is the site/camp designed, and is the design not increasing risk of GBV (e.g. schools not next to markets, no latrines near large clusters of trees or on outskirts of camp, etc.)? Are there understandable signs in the site that indicate where people need to go?

Acceptability: How are governance structures set up? Are women equally represented in governance structures? Do women participate in any form of committee? How does that affect the life of women on a site?

How is safety and security arranged in a site/camp/settlement? Is there police or community patrolling? Is there sufficient oversight? How is safety for women ensured?  
Quality: Do camp managers know about referral pathways for GBV and has this been shared with all actors on site/camp?

*Education:*

*Availability:* Are there sufficient educational facilities available? Is education available for children of all ages? If education is not available, what are increased GBV risks for children out of school? *Accessibility:* How far are schools and are there any financial fees that parents need to cover? Transport fees? Specific documentation required? Possibility to attend school for young mothers? Any other chores or labor children need to do that prevents them from attending school?   
Acceptability: Are there any social norms that prevent children (e.g. adolescent girls) from attending school? Are educational facilities sensitive to these?  
*Quality:* Sufficient trained teachers, enough female staff?

*Protection:*

Provide overall details on access to protection general legal services, documentation, general protection risk related to access to services. What is the awareness level of these services and how to access them?

*Child protection:*

Are boys/girls engaged in child labor and what are the associated GBV risks? Child marriage occurrence? Children left unattended and associated risks? Child recruitment into armed groups and associated GBV risks? What are specific needs for adolescent girls, boys, younger girls/boys?

Availability: Are child protection services available? Do child friendly spaces exist?

Accessibility: Can all children access CP services? What are risks to/from services? What are girls’/boys’ barriers to accessing child protection? What are barriers for children with disabilities? Do boys/girls feel safe at CP service?

Acceptability: What are parents’ attitudes towards CP services? Can children know about CP services in ways that are understandable to them?

Quality: Is there sufficient trained staff? Is there sufficient female staff?

## NEGATIVE COPING MECHANISMS

As a result of any disruptions in systems and services, are people using negative coping mechanisms? This can include the following:

* For women, reducing expenditure on non-food items (health, education, (female) hygiene items),
* For children, especially girls under 18, needing to dropout from school and work,
* Restriction of movement for women and girls,
* Transactional sex, sexual exploitation & abuse
* Harmful practices as a means to cope with stress triggered by the crisis, including: child marriage, forced marriage, female genital mutilation, breast flattening, hate crimes, child abuse linked to faith or belief and so called “honour-based” abuse and others.
* Substance abuse: As substance abuse is highly associated with GBV and violence in general, it is worth looking into the types of substances that are mostly used (alcohol, drugs, etc.) in this context, including studies or qualitative information on the correlation between substance abuse and GBV.

# Patterns and trends of GBV [2-3 PAGES]

## Types of GBV

Introductory paragraph documenting specific GBV types and GBV protection needs. I.e. from humanitarian profile, how many female headed households, child headed households, elderly headed households, etc. Are any disproportionately affected?

**If possible, provide** # of people estimated in need of GBV Protection. If available, use figures of GBVIMS to analyze patterns, illustrate narrative with quantitative data. **Do not use the number of incidents, rather use percentages (e.g. 40% of reported cases in July were cases of rape)**. **Do not make comparative analysis based on the number of incidents. Always specify that incidents do not mean prevalence, and that prevalence rates for GBV cannot be given**.

### Six core types of GBV

**What are the patterns and trends associated with the six core types of GBV:**

* Rape: non‐consensual penetration (however slight) of the vagina, anus or mouth with a penis or other body part. Also includes non‐consensual penetration of the vagina or anus with an object. Examples can include but are not limited to: gang rape, marital rape, sodomy, forced oral sex. *This type of GBV does not include attempted rape since no penetration has occurred.*
* Sexual Assault: any form of non‐consensual sexual contact that does not result in or include penetration. Examples can include but are not limited to: attempted rape, unwanted kissing, unwanted stroking, unwanted touching of breasts, genitalia and buttocks, and female genital cutting / mutilation. *This type of GBV does not include rape since rape involves penetration.*
* Physical assault: physical violence that is not sexual in nature. Examples can include but are not limited to: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in physical pain, discomfort or injury. *This type of GBV does not include female genital cutting / mutilation, or honor killing.*
* Forced marriage: The marriage of an individual against her or his will. This includes early/child marriage.
* Denial of resources, opportunities and/or services: denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples can include but are not limited to: a widow prevented from receiving an inheritance, earnings taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. *This type of GBV does not include reports of general poverty*.
* Psychological/Emotional Abuse: infliction of mental or emotional pain or injury. Examples can include but are not limited to: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

Data points that may be accessible from quarterly and annual GBVIMS (\*aggregated data at national level if sharable to GBV AoR according to the agreed ISP, in the absence of GBVIMS , check for CSO reporting)

* Most commonly reported among six core types of GBV incidents reported (rape, sexual assault, physical assault, forced marriage, denial of resources, psychological or emotional abuse) [percentages, data point 10]
* Most common case contexts of GBV incidents reported (IPV, Child sexual abuse, early marriage, possible sexual exploitation, sexual slavery, harmful practices, etc) [percentages,data point 12]
* Pattern of GBV by specific population group and geographical region

### Survivor and perpetrator profile

If available, briefly mention the demographic characteristics of survivors and perpetrators, as well as the patterns in terms of incident locations, relationships to the survivors?

### Location and context

Are there specific patterns or trends that require focused attention in relation to their profiles, the locations of incidents, and the occupations of perpetrators over a certain period of time? (yearly, quarterly trends)

### Service provision and referrals

Mention briefly whether survivors had access to service provision, and referrals within the past 12 months if the information is accessible from GBVIMS (percentages)

Example information might be helpful to summarise:

* Days between GBV incident and report date (percentages in each category0 [data point 13], is this increasing or decreasing over time?
* Percentage of rape survivors received the health service or referrals within 3 days, within 5 days, and after 5 days [data point 15]
* Services that showed low percentage of referrals within the GBVIMS incidents reporting and the underlying resons for no referrals (declined by survivor, no available services, etc) [data point 24]

## GBV CONSEQUENCES

As a result of the GBV situation, are there any existing and possible consequences that are of concern? Here are some possible questions that might be addressed:

### Individual consequences

* Are there many cases of health complications? This could include increases in STIs, unwanted pregnancies, physical injuries, higher mortality rates linked to sexual violence, UTIs, high numbers of people accessing unsafe abortions, fistula?
* Are there many cases of mental health and/or psychological/emotional distress?

### Community and social consequences

* How do the social consequences facilitate and/or prevent survivors of GBV from accessing needed assistance and/or recovering?
* Are there community/society level consequences that need to be considered? For example, are certain communities stigmatized?

# Humanitarian profile and CAPACITIES TO ADDRESS GBV [2 PAGES MAXIMUM]

### Humanitarian profile

Include a brief information on humanitarian profile, providing population figures disaggregated by gender, age, disability and diversity.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | IDPs | Migrants | Refugees | Returnees | Host community | Others |
| Women of reproductive age (15–49) |  |  |  |  |  |  |
| Female headed households |  |  |  |  |  |  |
| Pregnant and lactating women |  |  |  |  |  |  |
| People with disabilities |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |

\*adjust table and population groups to context

Include brief information on PiN for protection, GBV and targeted population? How much of the funding requirement for humanitarian services are funded in the previous and current years? Is the GBV funding increasing in relation to GBV PiN and targets?

### Capacities to address GBV

This provides an overview of existing capacities to address GBV in the context and can be analyzed by examining different levels of GBV intervention.

This should include the resources and capacities of local and international humanitarian actors to address GBV risk and needs either by mitigating the consequences or addressing the underlying risk factors of GBV identified in the earlier section.

What capacities exist in the affected location with available institutions, systems, and actors (community, municipality, area) to mitigate or respond to GBV? This includes identifying the extent to which these institutions, systems, actors, and people are functioning, available, and acceptable to the population.

What are actors who have the duty to protect doing to address GBV from a prevention, response, and accountability perspective? This includes overall institutional resources and capabilities to protect and respond, including justice and security institutions, informal mechanisms, as well as national and international protective mechanisms and responses.

How adequately are they addressing existing GBV needs? Are they able to reach the targeted populations?

This may include information about interagency coordination efforts, quality and adherence to GBV minimum standards, etc.

## CRITICAL GAPS in humanitarian capacities

Are there any critical gaps in GBV systems and services?? This should be linked to the urgent priorities/actions identified. Be sure to highlight the critical areas first. Include information on the following: prevention/preparedness, response, and coordination.

Questions that might be asked here are:

* Is there a preparedness plan for GBV before the crisis hits?
* Does the government have GBV prevention and response programming? Are services available and mapped clearly with roles and programs available? (Note: This should be in line with the GBV Minimum Standards)
* Are service mappings and referral pathways regularly updated?
* Are GBV SOPs are in place?
* How is the GBV AoR performing? This might be provided from the CCPM results, an evaluation, or some other data source.
* Any other information that provides a picture of the capacities of the systems to address GBV in the context

## LIMITATIONS

List any limitations that you encountered while searching for information/writing. These typically include: short timeframe for creating SDR therefore not all information included, not a lot of quantitative evidence, **the number of incidents does not imply prevalence and cannot be interpreted as such,** the numbers of people affected/displaced are inflated/deflated, unreliability of certain sources, methodology of assessment not suited to capture GBV protection needs, lack of Focus Group Discussion, lack of qualitative in-depth data, lack of assessments that capture the views of women and girls/use inclusive methodologies.