STANDARD OPERATING PROCEDURES

FOR PREVENTION OF AND RESPONSE TO

GENDER-BASED VIOLENCE

In

Kurdistan Region of Iraq

Date of approval:
1st Revision (after 6 months):
2nd Revision (after 1 year):
The Inter-Agency Emergency Standard Operating Procedures for Prevention of and Response to Gender-Based Violence in Kurdistan Region of Iraq were developed under the umbrella of the GBV sub-cluster in coordination with the Dohuk, Erbil and Suleymaniya GBV Working Groups. The document is the result of extensive consultation workshops with government ministries, national and international NGOs, academic institutions and women/civil society organizations. Thanks to the commitment of the GBV sub-cluster and working group members who attended the workshops, facilitated the consultation workshops and dedicated their staff to take notes of the SOP proceedings in all the governorates.

TABLE OF CONTENTS

ACRONYMS ..................................................................................................................................................5

CHAPTER 1: INTRODUCTION ..........................................................................................................................6
   1.1 International Instruments and Commitments ......................................................................................... 6
   1.2 Settings and Persons of Concern ........................................................................................................... 7

CHAPTER 2. DEFINITIONS AND TERMS ...................................................................................................... 7
   2.1 General Definitions and Terms .............................................................................................................. 7
   2.2 GBV Case Definitions for This Setting ................................................................................................. 11
   2.3 Other GBV-Related Terms ................................................................................................................... 11

CHAPTER 3. GUIDING PRINCIPLES ............................................................................................................ 12
   3.1 Guiding Principles for All GBV-Related Actions ............................................................................... 13
   3.2 Guiding Principles for Working with GBV Survivors ......................................................................... 13
   3.3 Guiding Principles for Working with Men and Boys Survivors ....................................................... 14
   3.4 Guiding Principles for Working with Child Survivors ..................................................................... 14
   3.5 Guiding Principles for Working with GBV Survivors with Disabilities ........................................... 16

CHAPTER 4. REPORTING AND REFERRAL SYSTEMS .............................................................................. 16
   4.1 Summary of the Interagency Referral System .................................................................................... 17
   4.2 Disclosure and Reporting .................................................................................................................... 18
   4.3 Relevant Mandatory Reporting Laws and Policies ............................................................................ 19
   4.4 Informed Consent and Information Sharing ....................................................................................... 19
   4.5 Protection from Sexual Exploitation and Abuse ................................................................................. 21
   4.6 Immediate Response Actions and Referrals ....................................................................................... 22
   4.7 Special Procedures for Working with Specific Groups ..................................................................... 23

CHAPTER 5: RESPONSIBILITIES FOR SURVIVOR ASSISTANCE ............................................................ 25
   5.1 Health/Medical Response .................................................................................................................... 27
   5.2 Mental Health and Psychosocial Response ......................................................................................... 29
   5.3 Security and Safety Response ............................................................................................................ 32
   5.4 Legal/Justice Response ....................................................................................................................... 34

CHAPTER 6. CASE MANAGEMENT ............................................................................................................. 39
   6.1 Responsibilities of Caseworkers and Agencies ............................................................................... 39
   6.2 STAFF CARE ....................................................................................................................................... 40
6.3 Steps of Case Management ................................................................. 41
6.4 Case Conferences ........................................................................... 41
6.5 Case Closure and Project Closure .................................................. 42
6.6 Mediation ....................................................................................... 42
6.7 Consent for Case Management with Children .................................. 43

CHAPTER 7. RESPONSIBILITIES FOR PREVENTION ........................................... 44
7.1 Prevention and Risk Mitigation for GBV Service Providers ....................... 45
7.3 Security and Legal Sector ................................................................ 50
7.4 Community Leaders Including religious leaders .................................. 50
7.5 Social Service and Civil Society Organizations ..................................... 51
7.6 Health/Medical Sector ..................................................................... 51

CHAPTER 8. INFORMING STAKEHOLDERS ABOUT THE GBV SOPS ............... 51
8.1 Information Dissemination to the Community .................................... 51
8.2 Information Dissemination to Other Organizations and the Government .... 52

CHAPTER 9. DOCUMENTATION, DATA AND MONITORING ................. 52
9.1 Maintaining Case Files .................................................................. 52
9.2 GBVIMS ...................................................................................... 53
9.3 Data Security ............................................................................... 53
9.4 Data Sharing Best Practices ............................................................ 54

CHAPTER 10. COORDINATION MECHANISMS ........................................... 55

SIGNATURES FOR PARTIES TO THE SOPs ................................................. 56

List of Annexes
Annex 1: Sample referral pathway
Annex 2: Referral Guidance Note
Annex 3: Inter-agency GBV referral form
Annex 4: Capacity to consent and best interest flow chart
Annex 5: GBV sub-cluster structure
<table>
<thead>
<tr>
<th>ACRONYMS</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIA</td>
<td>Best interest assessment</td>
</tr>
<tr>
<td>BID</td>
<td>Best interest determination</td>
</tr>
<tr>
<td>CMR</td>
<td>Clinical management of rape</td>
</tr>
<tr>
<td>CP</td>
<td>Child protection</td>
</tr>
<tr>
<td>DCVAW</td>
<td>Directorate for Combating Violence against Women (Kurdistan Regional Government)</td>
</tr>
<tr>
<td>FGM/FGC</td>
<td>Female genital mutilation/female genital cutting</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-based violence</td>
</tr>
<tr>
<td>GBV WG</td>
<td>Gender-based violence working group</td>
</tr>
<tr>
<td>GBVIMS</td>
<td>Gender-Based Violence Information Management System</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally displaced person</td>
</tr>
<tr>
<td>IPV</td>
<td>Intimate partner violence</td>
</tr>
<tr>
<td>ISIL</td>
<td>Islamic State of Iraq and the Levant</td>
</tr>
<tr>
<td>KRG</td>
<td>Kurdistan Regional Government</td>
</tr>
<tr>
<td>KRI</td>
<td>Kurdistan Region of Iraq</td>
</tr>
<tr>
<td>LGBTI</td>
<td>Lesbian, gay, bisexual, transgender, intersex</td>
</tr>
<tr>
<td>MHPSS</td>
<td>Mental health and psychosocial support</td>
</tr>
<tr>
<td>MISP</td>
<td>Minimum Initial Service Package for Reproductive Health in Crises</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>PFA</td>
<td>Psychological first aid</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post-traumatic stress disorder</td>
</tr>
<tr>
<td>PSEA</td>
<td>Protection from sexual exploitation and abuse</td>
</tr>
<tr>
<td>PSS</td>
<td>Psychosocial support</td>
</tr>
<tr>
<td>SEA</td>
<td>Sexual exploitation and abuse</td>
</tr>
<tr>
<td>SOP</td>
<td>Standard operating procedures</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>VoT</td>
<td>Victim of trafficking</td>
</tr>
</tbody>
</table>
CHAPTER 1: INTRODUCTION

Iraq is experiencing a double crisis of displacement. Syrian refugees, which total over 230,000 individuals, have fled the armed conflict in Syria and have sought refuge primarily in the Kurdistan Region of Iraq (KRI)\(^1\). Compounding this crisis is the larger scale internal displacement of Iraqis who flee territory held by the so-called Islamic State of Iraq and the Levant (ISIL) and the subsequent military operations led by the government and allied forces to regain territory. The country has been wracked by successive waves of displacement, with current estimates of 3 million internally displaced persons (IDPs) and over 1.4 million returnees, as well as 268,931 Syrian refugees in KRI\(^2\). The situations in KRI governorates are closely linked with humanitarian situation in other parts of Iraq. Over 1.2 million Ninewa residents have been displaced from their homes, and 386,460 of these people are displaced elsewhere in the governorate\(^3\). Meanwhile, Dohuk Governorate continues to host the majority of Syrian refugees and the second highest number of Iraqi IDPs (397,014), mostly from Ninewa\(^4\). The number of people in need of humanitarian aid in Ninewa has increased in 2017, particularly as the intensification of the Mosul military operation caused more displacement and other Iraqis are anticipated to return to their areas of origin.

Gender-based violence (GBV), particularly sexual violence, is a widespread and alarming element of the dual crisis. ISIL uses sexual violence as a tactic of terror and as a tactic of conflict, primarily targeting women and girls of specific ethnic and religious minority groups in Iraq and Syria. Those living in areas under ISIL control are at risk of rights violations, abduction, sexual slavery, rape, torture and abuse. However, the less recognized impacts of displacement affect far more refugees, IDPs and host communities. For Iraqis, displacement has exacerbated already high rates of intimate partner violence, honor crimes, sexual exploitation, harassment and child marriage that existed prior to the recent conflict. The vulnerability of certain groups, such as female-headed households, widows, women with disabilities and adolescent girls, compound the challenges they face. The specific needs of people at risk of GBV, especially women and girls, have been neglected across all sectors, while the potential to minimize GBV risks and provide quality multi-sector care for survivors is great.

These Inter-Agency Standard Operating Procedures (SOPs) describe guiding principles, procedures, roles and responsibilities in the prevention of and response to GBV by all relevant actors in the Kurdistan Region of Iraq (KRI).

The SOPs cover a broad range of beneficiaries, including IDPs, refugees, returnees, host communities and those who remained in their homes during and after military operations. The SOPs have been developed through an inter-agency consultative process with government institutions, UN agencies, national and international organizations and civil society actors working on GBV prevention and response. The SOPs have mapped out organizations responsible for service provision in the four main response sectors: health, psychosocial support, legal services and safety & security. They are designed to be used together with existing resources related to prevention and response to GBV. The SOPs have been developed to facilitate joint action by all GBV and non-GBV actors working in KRI to prevent and respond to GBV.

1.1 INTERNATIONAL INSTRUMENTS AND COMMITMENTS

- Universal Declaration of Human Rights (UDHR) (1948)
- UN Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (1949)
- Convention and protocol relating to the status of refugees (1951)
- UN Convention on the Political Rights of Women (1952)

\(^1\) UNHCR, 31 December 2016
\(^2\) IOM DTM, January 2017
\(^3\) Ibid.
\(^4\) Ibid.
• UN Convention Relating to the Status of Stateless Persons (1954)
• UN Convention on the Reduction of Statelessness (1961)
• International Covenant on Civil and Political Rights (1966)
• International Covenant on Economic, Social and Cultural Rights (1966)
• Declaration on the Protection of Women and Children in Emergencies and Armed Conflicts (1974)
• UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979) and Optional Protocol to the Convention (1999)
• UN Convention on the Rights of the Child (1989)
• International Convention on the Protection of the Rights of Migrant Workers and Members of their Families -resolution 45/158 (1990)
• The Beijing Declaration and Platform for Action (1995)
• UN Security Council Resolution, No. 1325 on women, peace and security (2000)
• Secretary General Bulletin on special measures for protection from sexual exploitation and sexual abuse (2003)
• UN Commission on the Status of Women (CSW) in 2004 and 2009
• UN Convention on Rights of Persons with Disabilities (CRPD) (2006)
• UN Security Council Resolution No. 1820 (2008)
• Family Related Crimes, Amended Iraqi Penalty code #((111) 1969 effective in Kurdistan Region-Iraq
• Act No. (14) From (2001), Act of indicating age of criminality in Kurdistan Region – Iraq
• 2005, Iraqi constitution five, chapters 29, 37, 45. (Shelter related)
• Act of labor and social affairs ministry number 12, 2007. (Shelter related)
• Act No. (8) From (2011), the Act of Combating Domestic Violence in Kurdistan Region – Iraq.
• Act of combating domestic violence. Number (8) 2011. (Shelter related)

1.2 SETTINGS AND PERSONS OF CONCERN

This SOPs cover a broad range of beneficiaries in KRI governorates, including IDPs, refugees, returnees, host communities and those who remained in their homes during and after military operations in KRI governorates to facilitate support to the most vulnerable persons. These groups include survivors of violence, female-headed households, widows, child-headed households, unaccompanied and separated children, stateless persons, people with disabilities, women and girls suffering discrimination and marginalization, men and boys who are sexually abused or forced to commit sexual abuse, and LGBTI individuals.

CHAPTER 2. DEFINITIONS AND TERMS

2.1 GENERAL DEFINITIONS AND TERMS
The following definitions and terms used in this setting are those established by the Inter Agency Standing Committee (IASC) in the *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery* (IASC 2015).

**Gender**: Refers to the social differences between men and women that are learned, and though deeply rooted in every culture, are changeable over time, and have wide variations both within and between cultures.

**Gender-Based Violence**: 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. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private. The term gender-based violence is most commonly used to underscore how systemic inequality between males and females—which exists in every society in the world—acts as a unifying and foundational characteristic of most forms of violence perpetrated against women and girls. It is important to note, however, that men and boys may also be survivors of GBV, and as with violence against women and girls, this violence is often under-reported due to issues of stigma for the survivor. GBV is a violation of universal human rights protected by international human rights conventions, including the right to security of person; the right to the highest attainable standard of physical and mental health; the right to freedom from torture or cruel, inhuman, or degrading treatment; and the right to life.

**Actor(s)**: refers to individuals, groups, organizations, and institutions involved in preventing and responding to GBV. Actors may be refugees/IDPs, local populations, employees, or volunteers of UN agencies, NGOs, host government institutions, donors, and other members of the international community.

**Affected community**: is the term used to refer to the population affected by the emergency. In humanitarian settings, the community may be refugees, IDPs, disaster-affected, host community, or another term.

**Armed groups**: are armed organizations that challenge the state's monopoly of legitimate coercive force. They include a variety of actors, including opposition and insurgent movements, pro-government militias, and community-based vigilante groups.

**Case management**: GBV case management is 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 that survivors are informed about all the options available to them, and that issues and problems facing a survivor are identified and followed up in a coordinated way. It has unique characteristics that distinguish it from other approaches to case management. The approach is called "survivor-centred."

**Caseworker**: This term describes an individual working within a service providing agency, who has been tasked with the responsibility of providing case management services to survivors. This means that caseworkers are trained appropriately on survivor-centered approach; they are supervised by senior program staff and adhere to a specific set of systems and guiding principles designed to promote health, hope and healing for their clients. Caseworkers are also commonly referred to as social workers, case managers, among others.

**Child**: is any person under the age of 18. The Convention of the Rights of the Child defines a 'child' as a person below the age of 18.

**Child labor**: Child labor generally includes all children below 12 years of age directly involved in any economic activity, and children below the minimum age for work (between 14 and 16) engaged in more than light work (i.e. work that does not threaten a child's safety or health, does not interfere with the child's education, does not take them away from their families, does not use up time for play or recreation or does

---

5 [http://www.smallarmssurvey.org/armed-actors/armed-groups.html](http://www.smallarmssurvey.org/armed-actors/armed-groups.html)


not hurt them physically, mentally or emotionally\(^8\). Child labor includes work that is mentally, physically, socially or morally dangerous and harmful to children; and work that interferes with their schooling. The concept of child labor is based on the ILO Minimum Age Convention (No. 138), and ILO Convention 182 details some of the worst forms of child labor, which can include slavery, sale and trafficking, forced or compulsory labor, recruitment of children for use in armed conflict, child prostitution, and drug trafficking.

**Confidentiality:** Confidentiality is an ethical principle that requires service providers to protect information gathered about survivors and agree only to share information about a survivor’s case with their explicit permission. All written information is maintained in a confidential place in locked files and only non-identifying information is written down on case files. All electronic information should be password-protected.

**Coordinating agencies:** are the organizations (usually two working in a co-chairing arrangement) that take the lead in chairing GBV sub-cluster and/or working groups (WGs) and ensuring that the minimum prevention and response interventions are put in place. The coordinating agencies are selected by the GBV sub-cluster and endorsed by the leading United Nations entity in the country (i.e. Humanitarian Coordinator, Special Representative of the Secretary-General).

**Informed assent:** 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 the expressed willingness of the child to participate in services.

**Informed consent:** Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent, and who exercises free and informed choice. 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.

**Internally displaced person (IDP):** IDPs are people who have been forced to flee their homes as a result of or in order to avoid the effects of armed conflict, internal strife, systematic violations of human rights or natural or manmade disasters and who seek protection elsewhere within their country of origin or residence and have not crossed internationally recognized state boarders\(^9\).

**LGBTBI:** collectively refers to people who are lesbian, gay, bisexual, trans, and/or intersex\(^10\).

**Mandatory reporting:** state laws and policies which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report actual or suspected interpersonal violence (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse)

**Perpetrator:** Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against his/her will

**Post-Traumatic Stress Disorder:** is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event\(^11\).

**Psychiatrist:** has a degree in medicine, followed by specialized training in the diagnosis and treatment of mental illness, emotional disorders, and behavioral problems. They may more often choose to prescribe medication in the treatment of difficulties\(^12\).

**Psychological First Aid (PFA):** is an evidence-informed approach that is built on the concept of human resilience. PFA aims to reduce stress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or even a personal crisis\(^13\).

---


\(^10\) National LGBTI health Alliance.

\(^11\) National institute of mental health.

\(^12\) British Colombia psychological association

\(^13\) Minnesota Department of health
Psychologist: has completed a bachelor’s degree and then continued in graduate training in psychology, and may have specialized in the assessment, diagnosis, and treatment of mental illness, emotional disorders, and behavioral problems. Although they may have training in the uses of medication to treat mental illness, they do not prescribe medication. Psychologists work to help people understand the nature of difficulties they may be dealing with, develop insight and skills to minimize and manage the impact of problems, and may coordinate with other health service providers, including physicians14.

Psychosocial support: helps individuals and communities to heal the psychological wounds and rebuild social structures after an emergency or a critical event. It can help change people into active survivors rather than passive victims15.

Refugee: any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of her/his nationality, and is unable to or, owing to such fear, is unwilling to avail himself/herself of the protection16.

Returnee: is a former refugee or IDP who returns to her/his country or area of origin, whether spontaneously or in an organized manner17.

Social worker: is a professional concerned with helping individuals, families, groups and communities to enhance their individual and collective well-being. He/she aims to help people develop their skills and their ability to use their own resources and those of the community to resolve problems.

Stateless Person: is a person who, under national laws, does not have the legal bond of nationality with any State. Article 1 of the 1954 Convention relating to the Status of Stateless Persons indicates that a person not considered a national (or citizen) automatically under the laws of any State, is stateless18.

Separated child: a child who is separated from both parents/caregivers or from his/her previous legal or customary primary caregiver, but not necessarily from other relatives. Compare with definition for unaccompanied child.

Survivor: Person who has experienced GBV. Though the terms “victim” and “survivor” can be used interchangeably, “victim” is a term often used in the legal and medical sectors and “survivor” is the term generally preferred in the psychological and social support sectors because it implies resiliency. For the purposes of the SOPs, the term “survivor” is preferred and used herewith.

Survivor-centered approach: seeks to empower the survivor by prioritizing her/his rights, needs and wishes. It means ensuring that survivors have access to appropriate, accessible and good quality services including: health care, psychological and social support19.

Trafficking of persons: The recruitment, transportation, transfer, harboring or receipt of persons, by means of threat, use of force or other means of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the receiving or giving of payment to a person having control over another person, for the purpose of exploitation20.

Trauma: Traumatic experiences usually accompany a serious threat or harm to an individual’s life or physical wellbeing and/or a serious threat or harm to the life or physical well-being of the individual’s child, spouse, relative or close friend. When people experience a disturbance to their basic psychological needs (safety, trust, independence, power, intimacy and esteem), they experience psychological trauma.

Unaccompanied child: a child who has been separated from both parents/caregivers and relatives and who is not being cared for by an adult who, by law or custom, is responsible for doing so. This means that

---

14 British Columbia psychological association
15 https://www.unicef.org
19 www.endvawnow.org/en/articles
20 UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Article 3, supplementing the UN Convention against Transnational Organized Crime
a child may be completely without adult care, or may be cared for by someone not related or known to the child, or not their usual caregiver e.g. a neighbor, another child under 18, or a stranger.

**Vulnerability**: Physical, social, economic, family, and environmental factors that increase the susceptibility of a community or individuals to difficulties and hazards and that put them at risk as a result of loss, damage, insecurity, suffering, and death.

### 2.2 GBV CASE DEFINITIONS FOR THIS SETTING

GBV Information Management System (GBVIMS) Classification of Six Core Types of GBV: The six core GBV types were created for data collection and statistical analysis of GBV. Any incident involving GBV can often involve more than one form of violence. GBV prevention and response actors should primarily use these definitions to classify incidents of GBV.

1. **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.

2. **Sexual Assault**: 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. Female Genital Mutilation (FGM) is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.

3. **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. **This incident type does not include FGM.**

4. **Forced Marriage**: The marriage of an individual against her or his will.

5. **Denial of Resources, Opportunities or Services**: Denial of rightful access to economic resources/assets or livelihood opportunities, documentation, restriction on movement, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. This does not include reports of general poverty.

6. **Psychological/Emotional Abuse**: Infliction of mental or emotional pain or injury. Examples include: 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.

### 2.3 OTHER GBV-RELATED TERMS

**Child Marriage**: A formal marriage or informal union before age 18. Child marriage is a reality for both boys and girls, although girls are disproportionately the most affected. It is widespread and can lead to a lifetime of disadvantage and deprivation. For the purposes of the SOPs, this term is preferred over the term "early marriage." Child marriage is a form of forced marriage.

**Child Sexual Abuse**: Refers to any sexual activity between a child and closely related family member (incest) or between a child and an adult or older child from outside the family. It involves either explicit force or coercion or, in cases where consent cannot be given by the survivor because of his or her young age, implied force.

**Conflict-related sexual violence**: Refers to incidents or patterns of sexual violence that occur in conflict or post-conflict settings or other situations of concern (e.g. political strife). They also have a direct or indirect nexus with the conflict or political strife itself, i.e. a temporal, geographical and/or causal link. In addition to the international character of the suspected crimes (that can, depending on the circumstances, constitute war crimes, crimes against humanity, acts of torture or genocide), the link with conflict may be evident in the profile and motivations of the perpetrator(s), the profile of the victim(s), the climate of impunity/weakened State capacity, cross-border dimensions and/or the fact that it violates the terms of a
ceasefire agreement.

**Domestic violence**: Used to describe violence that takes place within the home or family between intimate partners as well as between other family members

**Economic abuse**: money 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, a widow prevented from accessing an inheritance. *This category does not include people suffering from general poverty.*

**Harmful traditional practice**: is defined by the local social, cultural and religious values where the incident takes place. For example, “booking” girls for marriage but never marrying her, honor killing, female genital mutilation/cutting/circumcision, polygamy, forced marriage to settle a debt, forced marriage to perpetrator, forced marriage to settle a dispute, forced marriage because of killing, marriage exchange of women, forced marriage for financial reasons.

**Intimate partner violence**: Occurs between intimate partners (married, cohabiting, boyfriend/girlfriend or other close relationships), and is behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors, as well as denial of resources, opportunities or services

**Monitoring and reporting mechanism (MRM) on grave violations against children in situations of armed conflict**: is a Security Council-mandated mechanism, which requires the UN to collect information on six grave violations committed against children by all parties to a conflict after one or more parties to that conflict have been listed in the Secretary General’s Annual Report on Children and Armed Conflict. In collaboration with all relevant stakeholders, the MRM aims to end and prevent violations against children in the context of armed conflict, hold parties to conflict accountable for such violations, and provide appropriate responses to children affected by the conflict.

**Monitoring analysis and reporting arrangement on conflict-related sexual violence (MARA)**: aims to ensure the systematic gathering of timely, accurate, reliable and objective information on conflict-related sexual violence against women, men and children in line with UN provided guidance21. This information will be used to promote increased and timely action to prevent and respond to conflict-related sexual violence.

**Sexual exploitation**: The term ‘sexual exploitation’ means any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category

**Sexual harassment**: Unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature.

**Sexual violence**: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless or relationship to the victim, in any setting, including but not limited to home and work. Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion. The GBVIMS does not define sexual violence as one of the core types of GBV, but rather, as a category that includes, at least, rape/attempted rape, sexual abuse and sexual exploitation.

---

**CHAPTER 3. GUIDING PRINCIPLES**

Guiding principles are a set of norms which are considered best practice by international standards. They are not enforceable by law, but they are discussed and agreed upon by all intervening actors to ensure that

---

a minimum standard is achieved when dealing with a GBV case. All actors commit to extend the fullest cooperation and assistance to each other in the prevention and response to GBV and agree to adhere to the following principles as guides for their behavior, intervention, and assistance.

3.1 GUIDING PRINCIPLES FOR ALL GBV-RELATED ACTIONS

- Understand and adhere to the ethical and safety recommendations in the *WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies* (WHO, 2007);
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analysis and assessment information to avoid duplication and maximize a shared understanding of the situation;
- Establish and maintain carefully coordinated multi-sectoral and inter-organizational interventions for GBV prevention and response;
- Engage the community fully in understanding and promoting gender equality and power relations that protect and respect the rights of women and girls;
- Ensure equal and active participation by women, girls, men and boys in assessing, planning implementing, monitoring and evaluating programs through systematic use of participatory methods;
- Integrate and mainstream GBV interventions into all program and all sectors;
- Ensure accountability at all levels;
- All staff and volunteers involved in prevention of and response to GBV, including interpreters and refugee incentive staff, should understand and sign a code of conduct or similar document setting out the same standards of conduct.

3.2 GUIDING PRINCIPLES FOR WORKING WITH GBV SURVIVORS

There are 4 main guiding principles that must be adhered to during all interactions with survivors. These are **Respect**, **Safety**, **Non-Discrimination** and **Confidentiality**, which are discussed in an in-depth manner below:

**Safety**
- Ensure the safety of the survivor, her/his family and the service provider at all times.

**Confidentiality**
- Respect the confidentiality of the affected person(s) and their families at all times.
- If the survivor gives her/his informed and specific consent, share only pertinent and relevant information with others for the purpose of helping the survivor, such as referring for services.
- Nobody shares a survivor’s information without her/his permission.
- All written information about survivors must be maintained in secure, locked files and pass worded protected when electronic files are used.

**Respect**
- Respect the wishes, choices, rights, and dignity of the survivor.
- Conduct interviews in private and safe settings.
- For female survivors, always try to conduct interviews and examinations with female staff, including translators. For male survivors able to indicate preferences, it is best to ask if he prefers a man or a woman to conduct the interview. In the case of small children, female staff are usually the best choice.
- Believe the survivor and do not blame her/him for the violence she/he experienced.

---

• Be patient; do not press for more information if the survivor is not ready to speak about her/his experience
• Ask only relevant questions. (For example, the status of the virginity of the survivor is not relevant and should not be discussed). Do not encourage the survivor to disclose details of the incident if it is not 100% necessary in order for you to provide your service (e.g., medical care)
• Avoid requiring the survivor to repeat the story in multiple interviews
• The same case worker/manager should handle the survivor meetings through her/his case management process. This should be applied to mobile service delivery approaches as well.
• Use simple language that the survivor understands

Non-Discrimination
• Ensure non-discrimination in all interactions with survivors and in all service provision. Survivors of violence should receive equal and fair treatment regardless of their age, gender, race, religion, nationality, ethnicity, sexual orientation or any other characteristic.
• Be respectful and maintain a non-judgmental manner. Do not laugh or show any disrespect for the individual or his/her culture, family, or situation.

3.3 GUIDING PRINCIPLES FOR WORKING WITH MEN AND BOYS SURVIVORS

Male survivors of sexual assault require comprehensive, gender-sensitive response services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The response to male survivors is similar and the abovementioned guiding principles apply. Additional considerations include:

• Acknowledge that sexual abuse against men and boys exists: In general, males, especially adolescent males, may be much less likely to disclose and/or speak about their abuse experiences because being a survivor can be seen as a countercultural experience. Most abuse against boys occurs within the family circle, by adult men and women and by other children. Service providers must acknowledge that men and boys can be sexually abused and have the same needs as female child survivors—they need to feel safe, cared for, believed, encouraged and assured that seeking help and/or acknowledging sexual abuse is the right thing to do.
• Build trust with male clients: This entails active listening, believing the survivor’s story and using positive and affirmative messages. Clearly convey that their case will be handled confidentially
• Promote environment of inclusivity: Men and boys can be engaged during all phases of a GBV prevention and response program, starting from initial community outreach when promoting acceptance of GBV-related activities and awareness of available services. Men and boys should know that they too can receive GBV response services from case workers. If possible, seek ways to provide safe spaces for men and boys and activities that do not disrupt comfort and attendance of women and girls.
• Offer survivors a choice of trusted, sympathetic and competent service providers: e.g. medical, psychosocial support. Never assume that a boy or girl will feel more comfortable speaking with a service provider of his or her own gender. Rather, children should ideally be offered a choice of male or female service provider.
• Be aware of signs of sexual abuse against men and boys and educate clients about its effects: Often, male survivors will not sit comfortably, complain of the back aches (which signals potential rectal problems), show high levels of anger and homophobia, are unable to relate to other persons including family members, and will withdraw from social or community activities.

3.4 GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS

Promote the child's best interest:

• A child’s best interest is central to good care
• Service providers must evaluate the positive and negative consequences of actions with participation from the child and his/her caregivers (as appropriate)
• The least harmful course of action is always preferred. All actions should ensure that children’s rights to safety and ongoing development are never compromised.
• It is advisable for GBV actors to coordinate with Child Protection agencies with expertise and skills to respond appropriately

Ensure the safety of the child:
• 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 and long term

Comfort the child:
• Children who disclose sexual abuse require comfort, encouragement and support from service providers
• This means that service providers are trained in how to handle the disclosure of sexual abuse appropriately
• Service providers should believe children who disclose sexual abuse and never blame them in any way for the sexual abuse they have experienced
• A fundamental responsibility of service providers is to make children feel safe and cared for as they receive services

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 1) the confidential collection of information during interviews; 2) 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; 3) and that case information is stored securely.
• In some places where 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

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 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 empower and support children and deal with them in a transparent/caregiver manner with maximum respect.
• In cases where a child’s wishes cannot be prioritized, the reasons should be explained to the child

Treat every child fairly and equally (principle of non-discrimination and inclusiveness):
• 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, thereby giving them opportunities to reach their maximum potential. No child should be treated unfairly for any reason.

Strengthen children’s resiliencies:
• Each child has unique capacities and strengths and possesses the capacity to heal. It is the responsibility of service providers to identify and build upon the child and family’s natural strengths as part of the recovery and healing process.
• Factors which promote children’s resilience should be identified and built upon during service provision. Children who have caring relationships and opportunities for meaningful participation in
family and community life and who see themselves as strong will be more likely to recover and heal from abuse.

3.5 GUIDING PRINCIPLES FOR WORKING WITH GBV SURVIVORS WITH DISABILITIES

It is imperative to ensure that all men, women, boys and girls with special needs in need can access and receive GBV services in Iraq without discrimination. This is especially important since persons with disabilities, especially women and girls, are one of the most vulnerable groups to sexual and gender based violence. According to WHO, violence rates among persons with disabilities are 4 to 10 times higher than among those without disabilities.

The situation is even more concerning for those who have intellectual impairments (such as Down Syndrome, Autism, Attention deficit hyperactivity disorder, Asperger, Fragile X Syndrome, etc.) and mental health problems (chronic depression, anxiety, Bipolar Disorder, Schizophrenia, PTSD, etc.). Surveys conducted in the UK, the US and Australia showed that 70 to 90% of people with intellectual impairments or mental health problems have suffered some type of abuse during their lifetime. In almost all cases, the offenders are someone close or known to the survivors. This situation is even more concerning in developing and conflict-affected countries where stigma and discrimination tend to be higher – especially when it comes to women and girls.

The following are guiding principles that should be considered when working with persons with disabilities in GBV programs:

- **The right to participation and inclusion**: Recognize the diversity of the population, including the different risks faced by women, girls, men and boys with different types of disabilities in humanitarian settings.
- **Focus on the whole person, not their disability**: They have life experiences, skills and capacities, dreams and goals. They have many identities, including as mentors, leaders, wives, mothers, sisters, friends and neighbors.
- **Don’t make assumptions**: Do not assume that what a person with disabilities wants or feels or what is best.
- **Take time to consult with them**: Explore their interests and provide them with opportunities, as is done with other GBV survivors.
- **Identify and utilize strengths and capacities**: Work with people with disabilities, as well as their family members, to identify their skills and capacities, and use these to inform GBV program design, implementation and evaluation.
- **Work with people with disabilities through a collaborative process** that identifies their concerns, priorities and goals.
- **Avoid reinforcing negative power dynamics** by making decisions for them, and instead support them to develop their own sense of agency and power to make their own decisions.
- **Working with caregivers and families**: Disability also affects family members, particularly women and girls who may assume caregiving roles. Seek to understand the concerns, priorities and goals of caregivers, and to both support and strengthen healthy relationships and balanced power dynamics between caregivers, people with disabilities and other family members.

CHAPTER 4. REPORTING AND REFERRAL SYSTEMS

This chapter provides details on what GBV and non-GBV service providers can do when a survivor reports to them. The main points covered in this chapter are:

---

• Survivors of violence have multiple needs and coordination amongst service providers is crucial to meeting those needs. Regardless of number of cases being reported or seeking services, GBV actors must establish functional referral systems (see Annex 1 for sample referral pathway). The aim is to improve timely access to quality service for survivors of GBV.
• Case management agencies have the primary responsibility for ensuring they have a comprehensive area-specific service mapping and referral system in place in order to responsibly support survivors. GBV WGs serve a vital role in coordinating, consolidating, strengthening and supporting case management agencies in disseminating service mappings and referral pathways.
• The person/organization who receives the initial disclosure (report) of a GBV case should know that the survivor has the freedom to choose whether to seek assistance, what type(s) of assistance, and from which organizations. Health assistance is the priority for cases involving sexual violence and/or possible bodily injuries, especially within 72 hours. In the case of rape, assistance must be in accordance with the WHO Clinical Management of Rape guidelines and MoH/UNFPA Clinical Management of Rape (CMR) Protocol for Iraq25 and may include emergency contraception and post-exposure prophylaxis for HIV.
• Service providers will inform the survivor of what assistance they can offer and clearly relate what cannot be provided or any limitations to services, to avoid creating false expectations. All service providers in the referral network must be knowledgeable about the services provided by any actor to whom they refer a survivor. Children must be accompanied to all services within the referral pathway.

4.1 SUMMARY OF THE INTERAGENCY REFERRAL SYSTEM

The below model illustrates common “entry points” for survivors into systems of care and essential services to ensure comprehensive response to GBV, including referrals. Roles and responsibilities for each sectoral response to GBV can be found in Chapter 5.

A survivor has the freedom and the right to disclose an incident to anyone. He/she may disclose his/her experience to a trusted family member or friend. He/she may seek help from an individual or organization in the community.

Any service provider contacted by a survivor has a responsibility to give honest and accurate information about services available. In some settings, it may be possible for women’s groups to serve as a core part of the referral system and resource for other women in the community to seek help. For example, women’s group members can receive training on how to deal with disclosures of GBV incidents and be informed of all services available in the community, how and when to access them, to make safe and appropriate referrals.

Survivors should only be interviewed by those who are providing her/him with direct services (ideally psychosocial and health actors who can provide immediate emotional and/or medical support) to avoid survivors having to repeat their story in multiple interviews and risk re-traumatization if not handled appropriately. As such, all GBV service providers should ask only relevant questions and should not encourage the survivor to disclose details of the incident if it is not 100% necessary to provide the service. Do not pressure a survivor to share information that s/he is not comfortable sharing.

Non-GBV specialized actors should not interview the survivor, but if a survivor discloses a GBV incident that s/he experienced, the non-specialized actor should understand the referral system, available services, mandatory reporting policies, and consent, so that they can refer the survivor safely and appropriately.

If a service provider/non-specialized actor is provided with a report about a GBV Incident affecting a third party (e.g., the sister of a beneficiary or a neighbor etc.) or if they suspect a case of GBV based on their own observations:

- No referrals can be made as the direct consent of the survivor is necessary.
- Frontline workers should limit themselves to providing accurate information about services available and contact details of service providers and encourage the beneficiary to pass this
information along to the GBV survivor or woman/girl at risk and support her/him in her/his decision to seek help.

This limitation can be frustrating in case of urgent cases, but referrals made without the consent of the person directly affected can cause further harm and stigma. In cases of immediate risk/threats of life and in case of children, frontline workers are encouraged to contact immediately the case management agencies in their areas, refer the information they have received, and seek technical advice on how to proceed. Frontline workers should not undertake investigations to ascertain whether and to what extent what they have been referred is true or not.

4.3 RELEVANT MANDATORY REPORTING LAWS AND POLICIES

Confidentiality and informed consent should always be given priority. However, the rules of mandatory reporting are such that actors receiving information about certain types of violence are compelled by law or institutional policies to report this information to the police. It is important that survivors are made aware of these mandatory reporting rules, the types of information which may trigger them, and the possible consequences of reporting, before beginning an interview. After providing a survivor with this information, a survivor may choose not to disclose some information about the incident (such as the occupation of the perpetrator), which is within her/his rights. Services should still be provided according to the information that is shared and according to the wishes of the survivor.26

All public servant (government employees) are required to report misdemeanors and felonies, which includes incidents of rape, according to Article 48 of the Iraqi Criminal Procedure Code No. 23 of 1971. Public servants who are obliged to report but willfully choose not to be subject to detention or fine under Article 247 of the Iraqi Penal Code No. 111 of 1969. According to the Ministry of Health CMR Protocol from 2017, the proposed procedure would be that “the medical response services to survivors should be immediate and unconditional to any mandatory reporting policies or procedures that constitute an impediment to access to these services. Additionally, the decision by the survivor to refrain from taking legal action should not have negative repercussions for survivor’s access to health services. The provision of lifesaving, timely and confidential health care to a survivor is the first priority”. If the survivor chooses to take a legal action, the medical certificate can be used to fill information into other required legal forms on request after appropriate medical services have been provided. Once a directive is issued by the federal Ministry of Justice or Ministry of Interior to suppose these proposed procedures, they will go into effect. In the meantime, health workers should provide care immediately, first before the police officer arrives. For more information for health workers, please refer to the Protocol.27

Although there is no legal framework mandating reporting of actual or suspected child abuse or neglect, institutions may have policies in place that require employees to report such cases to the police or management.

4.4 INFORMED CONSENT AND INFORMATION SHARING

Information about GBV incidents is extremely sensitive and confidential. Sharing any information about a GBV incident can have serious and potentially life threatening consequences for the survivor and those helping her/him. Great care is therefore needed in managing information, and GBV survivors have a right to control how information about their case is shared with other agencies or individuals.

Informed consent means that a person agrees to participate in an activity or for something to occur after s/he has knowledge of or has received all the information about the activity. In order to give informed consent, a person must:

- Have all the information

• Be over the legal age required to give consent
• Be mentally sound enough to understand the agreement and the consequences
• Have equal power in the relationship.

Informed consent is necessary before any information is shared with others. To ensure consent is informed, service providers must explain:

- All the options that are available
- That information (as agreed with the survivor) will be shared with others in order to access other services; she has the right to place limitations on the type(s) of information to be shared, and to specify which organizations can and cannot be given the information.
- Exactly what is going to happen as a result of accepting other services
- The benefits and risks of the service
- That survivors have a right to decline or refuse any part of the service offered by you or the referral agency
- Mandatory reporting policies as described above
- Information in such a way that persons with disabilities understand it, using alternate means of communication where necessary

There is no consent when agreement is obtained through:

- The use of threats, force or other forms of coercion, abduction, fraud, manipulation, deception, or misrepresentation
- The use of a threat to withhold a benefit to which the person is already entitled to
- A promise is made to the person to provide a benefit

Confidentiality and informed consent should always be given priority, except in very exceptional circumstances:

- when a survivor threatens his/her own life
- when a survivor threatens to seriously harm another person
- when child abuse or neglect is suspected and it is in best interest of the child
- all suspected incidents of sexual exploitation and abuse
- when mandatory reporting rules apply

The survivor must also understand the option of sharing non-identifying data about her/his case for data collection and security monitoring purposes and consent to this sharing. This should be included in the consent form and clearly explained to the survivor.

The survivor has the right to place limitations on the type(s) of information to be shared, and to specify which organizations can and cannot be given the information. Sharing of information between agencies should be guided by the referral guidance note (Annex II).

Detailed information about the specific case should only be shared outside the service provider to a specific actor for a determined purpose if the survivor consents. This includes beneficiaries of case management, medical and group or individual psychosocial support services. Thus, case information should not be shared with the donors or other actors not involved in the direct care of survivors or other clients without the explicit informed consent to share information with that particular entity and reasonable reason for sharing that benefits the survivor/client. When information is shared outside of service provision, informed consent must include explaining to the survivor what information will be shared, how that information will be handled and used, the benefits/risks of sharing the information, her rights to limit the types of information shared, etc.

See Chapter 9.3 on Data Security and 6.5 on Case Closure.

---

28 Confidentiality should only be broken when there are indications that the person is planning to take their own life. Suicidal thoughts can be common among survivors of violence and are by themselves not sufficient to indicate that the person is planning to take their own life. If in doubt, case managers should consult a mental health professional. In all cases when a person reports thoughts of suicide they should be counselled on available mental health services.
4.5 PROTECTION FROM SEXUAL EXPLOITATION AND ABUSE

Sexual Exploitation and Abuse (SEA) by aid workers is a serious problem that directly contradicts the very principles of humanitarian action. Perpetrators exploit unequal power relationships through the use of physical force or other means of coercion—for example, threats, promise of food or services, withholding aid, giving preferential treatment—to obtain sexual acts from a more vulnerable person. Not only does SEA inflict harm on those whom we are mandated to protect, it also jeopardizes the credibility and reputation of all humanitarian organizations.

In July 2016, the Resident Coordinator (RC)/Humanitarian Coordinator (HC) established the inter-agency Iraq Protection from Sexual Exploitation and Abuse (PSEA) Network. The Network’s main objective is to implement the Secretary-General’s Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse (ST/SGB/2003/13) and to promote further accountability to affected populations.

The PSEA network in Iraq is co-chaired by UNFPA and WFP Country Representatives who report directly to the RC/HC. Membership includes one Focal Point and one Alternate from each UN Agency operating in Iraq and from UNAMI, as well as a dedicated Coordinator and a Co-Coordinator.

The PSEA Network has Standard Operating Procedures (SOPs) on receiving, recording, logging, and referring cases of SEA to relevant agencies for follow-up and assistance (as required). These SOPs should complement each Organization’s internal PSEA policies.

Making a Complaint

According to the SG Bulletin, which serves as the UN’s Code of Conduct for PSEA, all UN Staff, humanitarian workers, and anyone who has entered into a partnership or cooperation agreement with the UN, including contractors, volunteers, day labourors, etc. must report any suspicion of SEA.

A complaint can be made by or on behalf of a survivor through the UN IDP Call Centre (800699999) where operators have been specially trained to deal with SEA cases. A complaint can also be submitted to other complaints mechanisms, or directly to the PSEA Network Coordinators (emond@unfpa.org; phyza.jameel@wfp.org). Complaints should be submitted on the SEA Complaints Form (see Annex) and should include as much information as possible regarding the survivor, the incident, and the alleged perpetrator.

Referral and Investigation:

The PSEA Coordinator will log the complaint and will refer it to the concerned Agency’s PSEA Focal Point no later than 36 hours after reception. The concerned Agency is the Agency where the alleged perpetrator works or holds a contract (i.e. an employee of an Agency’s Implementing Partner or contractor).

The concerned Agency is then responsible for following its internal PSEA procedures to conduct an investigation and to feedback to the PSEA Network Coordinator on the status of the complaint.

If the complaint does not provide sufficient information to refer the case (for example, if the affiliation of the alleged perpetrator is unknown), the PSEA Coordinator will convene a small committee of 3-4 PSEA Network members to gather further information.

Confidentiality

The PSEA Network will ensure that all data is safe and secure and will implement appropriate procedures to maintain confidentiality of the data.

Prior to recording a complaint, the complainant should be informed of the mandatory reporting rule and the PSEA Network’s confidentiality policy and consent should be obtained for the information to be made available to others within the Complaints Management System (the PSEA Network Coordinators, the PSEA Focal Point and the Head of the concerned Agency).

If a survivor wishes to remain anonymous and does not give consent to follow-up, humanitarian personnel still have a duty to report the case, keeping details about the victim anonymous.
Survivor Assistance:

Given that SEA is a form of Gender-Based Violence (GBV), if the survivor requires and consents to assistance, the PSEA Coordinator immediately refers him/her to the GBV sub-cluster for follow-up. N.B. Survivor assistance is in no way linked to the outcome of the investigation.

### 4.6 IMMEDIATE RESPONSE ACTIONS AND REFERRALS

For cases of sexual and physical violence, urgent health care is the number one priority for survivors due to the life-threatening nature of incidents and time-bound treatment for certain illnesses that can result from GBV. In these cases, encourage the survivor to seek health care, ideally within 72 hours of a GBV incident. In the case of rape, assistance must be in accordance with the WHO/ Clinical Management of Rape guidelines and the Iraq Ministry of Health Clinical Management of Rape Protocol and may include emergency contraception and post-exposure prophylaxis for HIV.

If a survivor discloses violence, providing her/him with supportive, healing messages are important for healing, building trust, and empowering the survivor. A list of healing messages is provided below. If you are amongst others, thank the survivor for sharing and ask if she would prefer to speak with you alone afterward.

**Healing Statements**

<table>
<thead>
<tr>
<th>Build relationship / rapport</th>
<th>“Thank you for sharing that with me” / “I’m glad that you told me”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Empathy</td>
<td>“I’m sorry to hear what happened to you” / “I’m sorry to hear you are going through this”</td>
</tr>
<tr>
<td>Trust</td>
<td>“I believe you”</td>
</tr>
<tr>
<td>Reassuring &amp; Non-Blaming</td>
<td>“What happened to you is not your fault” / “You did not deserve what happened to you”</td>
</tr>
<tr>
<td>Empowering</td>
<td>“You are very brave to talk with me and I will try to help you.”</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>“I want to let you know that what you shared is confidential and I won’t tell this to anyone else without your consent”</td>
</tr>
</tbody>
</table>

The person who receives the initial disclosure or report of a GBV incident from a survivor will act in accordance with the referral mechanism illustrated in ANNEX 1.

- All GBV Service Providers should know the GBV referral pathways and the forms of assistance that are available in their setting
- Provide direct interventions, including psychosocial interventions, if appropriate;
- **When referring a survivor for services always ask for his/her consent**
  - With the consent of the survivor, refer her/him to the appropriate services for follow-up support and advocate (if required) in accessing the required services;
  - Contact the primary focal point on the GBV referral pathway for your location and facilitate the contact between service provider and survivor to arrange for follow-up care. Information about referrals should be kept to a minimum; do not discuss sensitive information with anyone but the GBV focal point, including other staff from your organization.
- Ask the survivor if s/he would like to be accompanied to the agency to which she is being referred.

---

• If the survivor does not want to access services, provide them with details of service providers in your area in case they want to use them in future
• The wishes of the survivor must always be respected she has the right to decide
• A survivor should not be urged or forced to take a particular course of action;
• Referrals should be done using the coded Inter-Agency GBV Referral Form (see Annex III) which does not include the name, address, or any other information that might identify the survivor. Always prioritize the confidentiality and security of survivors. The referral form is sent by email and is password protected. (Only focal points know the passwords for the referral forms)

See Chapter 9.3 on Data Security

4.7 SPECIAL PROCEDURES FOR WORKING WITH SPECIFIC GROUPS

4.7.1 CHILD SURVIVORS OF GBV

Child-centered approach should be utilized that focuses on the short-term and long-term best interest of the child. The child survivor of GBV should be at the center of any reporting and referral mechanism, reflecting the principle of respect for survivor’s choice and having the child participate in the decision making. A clear referral system ensures that the service providers know how to provide timely assistance.

Obtaining consent when working with child survivors of GBV should be done as follows:
• Information should be shared in languages and formats appropriate to the child’s age and capacity to understand. Service providers are responsible for communicating in a child-friendly manner and should encourage the child and their family to ask questions that will help them to make a decision regarding their own situation.
• In the KRI, the parent/caregiver’s (or other responsible adult’s) legal consent should be obtained for children under 18 years of age. However, if a child has reached the age of 15 years old and if the parent/caregiver is not able or willing to provide consent, the child’s informed consent may be obtained instead of the caregivers. Otherwise the parent or caregiver should be included with the child’s permission.
• Informed assent is expressed willingness to participate in services, and is sought from children who are by law or nature too young to give informed consent, but who are old enough to understand and agree to participate in services. Children between 6 and 15 years can provide informed assent; however, permission is also required from the parent or caregiver.
• Although it may not be possible to obtain informed consent or assent from younger children, efforts should still be made to explain in language appropriate to their age, what information is being sought, what it will be used for, and how it will be shared.
• Consent can be obtained in verbal or written form; however, written consent should always be sought where possible.
• Children and caregivers should be made aware of any relevant mandatory reporting requirements.
• There may be cases in which it is not appropriate to obtain parent/caregiver consent, including where the caregiver may be the perpetrator or complicit in the abuse, or where unaccompanied children are involved. In such cases, wherever possible the consent of another trusted adult should always be sought for children under 15 (for the purposes of these SOPs, a “trusted adult” is a related adult, or adult caregiver nominated by the child). For children above 6, they should participate in identifying this person. Where such person is not available, the case manager may have to provide consent for children under 15.  
• Any decision to take consent from anyone other than the parent, caregiver, legal guardian or nominated trusted adult should be reviewed by a qualified person/supervisor. The process should also be documented on the consent form.

30 Family Related Crimes, Amended Iraqi Penalty code #(111) 1969 effective in Kurdistan Region- Iraq
All actors providing services to survivors should have staff adequately trained to handle the specific needs of child survivors. Upon receiving the initial report from a child survivor, an assessment should be made of the child's medical, psychosocial, legal and security needs.

Prior agreement should be made between GBV and CP actors as to which organization will be the primary focal point to receive referrals of child survivors of GBV and provide case management, depending on which actor has staff available, trained and capable of caring for child survivors. This should be reflected on local referral pathways. The primary focal point organization for child survivors is responsible for the initial documentation requirements such as completion of intake forms and overall case management. Ideally, all GBV and CP actors should have trained and supervised staff capable of caring for child survivors so to respect the survivor's choice of to whom to report, avoid having the child survivor report her/his story multiple times, and reduce risk of child survivor not following through with the referral and receiving care.

GBV actors should coordinate with Child Protection actors who are trained to respond to specialized child protection aspects, such as family tracing, reunification and alternative care arrangements for unaccompanied and separated children as well as best interest assessments (BIA) and best interest determinations (BID). A well-trained and skillful social worker, community counsellor or child protection advocates are recommended to make this assessment. The parents or guardian of the child should be informed about the on-going interview and supported to provide the best care possible for the child. However, if the parent or guardian is a potential perpetrator, the child should be given the chance to talk privately to the social worker or counsellor.

### 4.7.2 GBV SURVIVORS WITH DISABILITIES

The flow chart in Annex 4 can help navigate the informed consent process with a survivor with a disability by helping determine their capacity to consent and when it may be in the best interest of the survivor to get consent from a family member or caregiver, or take action on behalf of the survivor.

Specific considerations need to be taken in account while communicating with persons with different types of impairments. Interviewers should ask the survivor and/or care giver (if survivor gives consent) how best to communicate with them before attempting multiple methods of communication. Or ask the survivor to include a care-giver or trusted person who knows how to communicate with them for hearing/speech/intellectually impaired.

**Physical impairment:**
- Discuss transportation options for activities and events. Consider what is going to be the safest, most affordable and the least amount of effort for the individual and family.
- Meet with people in a place where they can access easily with enough privacy.
- Sit at the person's level if using a wheelchair.
- Do not lean on or move someone's wheelchair or assistive device without their permission.
- Be sensitive about physical contact.

**Hearing impairment:**
- Find out how the person prefers to communicate. People with hearing impairments may use lips-reading at their interactions with others or by using simple gestures to suggest communication options.
- Ask if the person understands and uses sign language and always face and talk directly to the person.
- Allow the person who has a hearing impairment to choose the best place to sit at a meeting to be able to see people clearly and communicate more easily.

---

31 For more info on obtaining informed consent for GBV survivors with disabilities, please refer to Tool 9 of the Women's Refugee Commission’s GBV Disability Toolkit: [https://www.womensrefugeecommission.org/?option=com_zdocs&view=document&id=1173](https://www.womensrefugeecommission.org/?option=com_zdocs&view=document&id=1173)
Use gestures/pictures or a communication board.

**Visual impairment:**
- Always introduce yourself and any other people in the group by name.
- Avoid pictures, written documents and vague language, such as “that way” or “over there” when directing or describing a location.
- If pictures need to be used, describe in as much detail as possible what is in the picture.
- Tell the person if you are moving or leaving their space — don’t just walk away.
- Prevent the person from running into any physical obstacles.
- Give an initial tour, describing the environment to the person in their first visit to make them comfortable with the new place.

**Intellectual impairment:**
- Communicate in short sentences that convey one point at a time.
- Use real life examples to explain and illustrate points. For example, if discussing an upcoming visit/session, take the person through the steps they are likely to go through both before and during the appointment.
- Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, then repeat it once. If this doesn’t work, then try again using different words.
- Make sure that only one person is speaking at any given time, and that the person with an intellectual impairment is not being rushed to answer.
- Identify quiet environments to have conversations in order to reduce distractions.
- Pictures can also be used to communicate messages to people with intellectual impairments these are sometimes called “Easy to Read” documents.
- Always treat adults as adults. Never use a childish tone of voice.

**Speech impairment:**
- Plan more time for communicating with people with speech impairments.
- It is OK to say “I don’t understand.” Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly.
- Don’t attempt to finish a person’s sentences — let them speak for themselves.
- Try to ask questions that require short answers or yes/no gestures.

**CHAPTER 5: RESPONSIBILITIES FOR SURVIVOR ASSISTANCE**

This chapter specifies the role of specialized actors in dealing with GBV cases. Specialized actors can receive cases either through disclosure from survivors or through referral from other actors. All specialized service providers should ensure that frontline services are accessible, safe, private, confidential and trustworthy. Survivors are more likely to come forward to seek help and report a GBV incident when such conditions are conducive.

**HOME VISITS**

Home visits to GBV survivors present a high risk of safety for the survivor, her/his family and the service provider, whether a legal, case management, health or other protection service provider. In most situations, it would be better to identify a safe space in the community that is easily accessible for survivors and would still allow for some privacy and safety. **Home visits are not recommended when supporting GBV survivors,** unless agreed with the service provider and the survivor and risks are discussed. Do not conduct

---

any home visits if this action might put the survivor at risk or be stigmatizing. In some places, due to general security concerns, home visits may be the only way to reach survivors, and there are strategies to put in place to minimize risk to survivors and staff. This includes conducting home visits very discreetly and keeping a low profile:

- Visit multiple households at a time to provide information or some other type of service not related to GBV. Visiting a survivor’s household in that area during this time may thus not draw attention.
- Discuss with the survivor what time of day and which days fewer community members will be around, and when the perpetrator will not be in or near the house. To the extent possible, set aside a specific time with the person so they know when to expect you.
- Make a plan with the survivor to have a code or signal that they can use to let you know that it is no longer safe for you to come to their house. This could be a message sent through a mobile phone, something that the person puts on or near the home (cloth of a certain color, a stick), or something that is changed within the home so that if you do enter, you will know that it is not safe to speak with the person.
- In the event that the survivor is confronted about your visit, discuss with the person what they can say to others about who you were and why you were visiting so that they do not expose themselves.

Be aware that any information you request of the survivor in the presence of relatives or other members of the community might have an impact on his/her protection.

Home visits should never be used to ‘identify GBV cases’. Organizations responding to GBV should not go out in communities to actively identify GBV cases. Outreach teams may visit homes to provide information about services in the community, but these visits should never include any questions or discussions about personal experiences of violence in the household.

DISABILITY INCLUSION / PERSONS WITH SPECIAL NEEDS

To ensure that all persons with disabilities have access to GBV services in Iraq should they need it, a few procedures need to be put in place:

- Identification is the first step to mainstream persons with disabilities (especially those with intellectual impairments and mental health problems due to stigma and shame of the family) into GBV services. Persons with disabilities tend to be “invisible”; a proper tool for identification and outreach activities need to be implemented to ensure that persons with disabilities will be identified by service providers in different contexts. Assessment tools need to include specific questions, preferably the Washington Group questions33 which will allow for more diverse data of those in need of GBV related services, even those whose impairments are not visible34.
- Physical accessibility to persons with different types of impairments: Structures where activities take place need to be accessible to all. Universal accessibility includes: ramps with the correct gradient, doors with a minimum width of 90 cm, indoor spaces without barriers to movement (such as furniture, open doors and windows), accessible toilets and shower facilities (with handrails and enough space for wheelchair users to move freely), tactile markings on pathways and at the top and bottom of stairs and ramps, stairs with handrails and steps of equal dimensions, etc.
- Information and communication need to be in accessible format. Accessible communication means staff trained in sign language or in alternative techniques on how to communicate with persons with disabilities and activities which allow persons with different types of impairments to participate on an equal basis. Accessible information requires that as much as possible IEC materials are available in Braille or audio version, illustrations, large font, contrasting colors, etc.
- Staff have to have a positive and welcoming attitude to persons with disabilities. Negative attitudes are one of the biggest barriers for persons with disabilities to access and use different services. Awareness sessions and trainings for the staff on how to deal with persons with disabilities need to be done to ensure a welcoming and comfortable environment. Furthermore, awareness sessions

33 https://www.cdc.gov/nchs/washington_group/wg_questions.htm
should be done to families so as to increase the number of persons with disabilities willing to
engage in GBV support activities.

- Adapt monitoring tools to ensure the follow-up and results of the service provided are indeed
supporting and benefiting the person. Questions related to disabilities and tailored to different
projects need to be included in monitoring tools. General indicators of success are positive changes
in family dynamics, in the overall state of the beneficiary or increase in their participation in general
social activities.

5.1 HEALTH/MEDICAL RESPONSE

Medical personnel play a major role in cases of sexual violence and exploitation, and they are often first
responders. Generally, physicians are responsible for working with nurses to treat injuries, conduct a
thorough medical screening and forensic exam, provide psychosocial support, and give appropriate
referrals and follow-up. All services should be in line with global standards, protocols and practices outlined
in the Ministry of Health’s Clinical Management of Rape (CMR) Protocol for Iraq and the CMR Guidelines
(WHO/UNHCR, 2004) that ensure confidential, accessible, compassionate, and appropriate medical care.

Medical personnel should identify who are the first points of contact when a survivor enters the health
system and ensure they are equipped to provide basic immediate psychological support and facilitate
treatment of the patient. Ideally, these staff and the physicians providing services have been trained to
provide specialized services, including a forensic examination and (at least initial) trauma counseling.

*Medical personnel should never determine whether sexual assault occurred.* That is a legal
determination. Medical provider’s responsibility is to provide care, as well as record details of the history,
the physical exam, and other relevant information, and, with the survivor’s (and/or parent’s) consent, collect
forensic evidence that might be needed in subsequent legal action.

5.1.1 CLINICAL MANAGEMENT OF RAPE

The Iraq Ministry of Health’s Clinical Management of Rape Protocol details the exact roles, responsibilities
and actions that medical providers should take when caring for a survivor of sexual and physical violence.
For example, the Protocol guides providers on how to:

- Prepare their clinics to offer medical care to rape survivors
- Prepare the survivor for the examination
- Take the history
- Collect forensic evidence
- Perform the physical and genital examination
- Prescribe treatment
- Counsel the survivor
- Follow-up care of the survivor

*Important to note is that all PHCs, hospitals and NGO-supported PHCs and Mobile Medical Units
(MMU) should be providers of CMR services as long as all they have post-rape care supplies, trained
staff and a registered Iraqi physician.*

The Protocol recognizes that mandatory reporting practices and/or procedures can impede survivors’
access to lifesaving health services regardless of whether the survivors decide to take legal action on their
case or not, and whether medical service providers need to report the case to the police or not. Within the
CMR protocol, the following procedures and practices will be applied in order to ensure that lifesaving health
care for survivors is prioritized and adhere to survivor-centered principles.

- Survivors of sexual violence, including survivors of rape, regardless of whether they decide to
pursue legal action or not must be provided with immediate medical responses: including medical
examination offered, medications administered to them to prevent infections and unwanted
pregnancy and consent-based referrals to other specialized hospital departments (including for
forensic examination if requested), all according to the survivors’ wishes, decisions and consent.
• Survivors of sexual violence should not be prevented from accessing health care because of not consenting to reporting to the police. The provision of adequate and timely health care to a survivor is the first priority.

• Qualified and CMR-trained medical staff can provide a primary medical report filled in by the clinician attending the survivor and kept confidentially in a safe place.

• All medical staff providing care to survivors must provide services and referrals based on the informed consent from the survivor, confidentiality, safety, nondiscrimination and respect that adheres to survivor-centered care. The needs, wishes and best interest of the survivor take precedence over any mandatory reporting to authorities.

• Medical staff should adhere to GBV guiding principles for providing survivor-centered care when performing further physical examinations, collecting forensic evidence, providing a medical certificate, informing the survivor of other services (such as counselling) and providing referrals. If available, women community health officers’ accompaniment should be offered to the survivor for referrals to other services.

• If the survivor chooses to take a legal action, the medical certificate can be used to fill information into other required legal forms on request after appropriate medical services have been provided.

Sexual violence survivors should be offered follow-up health and psychological care regardless of whether or not they decide to pursue legal action. All procedural and legal frameworks remain secondary to providing safe, confidential lifesaving health care for survivors of sexual violence.

Refer to Iraq CMR Protocol 2017 for further details³⁵

5.1.2 REFERRALS AND SEXUAL/REPRODUCTIVE HEALTH

Ensuring women, girls and GBV survivors have unimpeded access to a full range of health services, including sexual and reproductive healthcare (SRH) beyond clinical management of rape, is critical.

Autonomy over Patient's Own Healthcare Decisions: Women and girls are entitled to autonomy and choice over their own healthcare decisions and do not need consent from male relatives, guardians or husbands to receive care or referrals. In Iraq, the only service where consent from a husband or male guardian is required is for sterilization. As per law any police case, need case reporting, for minors, as per the law its needed but for adult a consent to report should be obtained from the patient regardless the gender.

For all other situations, including CMR, contraception, family planning and STI management, health workers should not ask for consent from a male guardian to provide women and girls with services. Health providers commit to providing quality care (i.e., not denying services, especially SRH) without stigmatizing or shaming women, girls and GBV survivors for their choices of services. For men or women who test positive for an STI, the spouse must be notified as part of case tracing to ensure an infected partner gets tested and receives treatment. For surgery, including caesarean section, a next of kin will need to be identified, and can include a spouse or any other relative to sign. In case the husband is not available and for some reasons relatives of the woman chose not to sign, then a weaver may be required to save the life of the woman. Women in labor can be admitted alone to the hospital, without the need of having the husbands or male relatives present. Women are asked for their name, husband’s name, and other biographical information. Following delivery, women receive a document proving the date of delivery and are asked to return in a few weeks with the required documents to receive the birth certificate. One of the required documents to receive a birth certificate is the marriage certificate. The husband does not need to be present to receive the birth certificate, but the marriage certificate is required. In case where one parent is a foreign national or if the foreign parent has passed away or is no longer in country, a legal referral may be necessary.

in order to obtain a birth certificate. Legal referral may also be needed when missing identity and/or civil documents.

**Access:** Health workers also play an important role in helping advocate on behalf of women and girls to access care both in their location and referrals elsewhere. Women and girls face particular challenges in accessing timely care. Advocating for access with security personnel should ensure confidentiality is not breached and info is not shared without the explicit consent of the survivor. In general, IDPs and refugees living in host communities can go on their own to the local hospital without a referral from a PHC (pending exceptions due to security apparatus). If there are no SRH services within a camp, the PHCC can issue a referral paper to facilitate the movement of the patient to a RH service. This paper needs to be signed by the camp manager.

**Abortion:** At present, abortion is illegal in Iraq both for the patient and the health worker, whether consensual or otherwise\(^{36}\). However, “if a woman, having become pregnant through fornication, procures her own miscarriage out of shame it is considered to be a legally mitigating circumstance. The same is true in respect of any woman whose pregnancy is terminated by a relative to the second generation”\(^{37}\). Additionally, health workers do not face legal consequences for caring for women and girls who experience complications of self-induced abortions and thus do not need to report suspected cases to the police.

Decisions to terminate a pregnancy is done ONLY when a woman’s health is at risk. A special committee of professionals takes the decision.

### 5.2 MENTAL HEALTH AND PSYCHOSOCIAL RESPONSE

Mental health and psychosocial support (MHPSS) indicates any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder. According to *Inter-Agency Standing Committee Guidelines for MHPSS in Emergencies* (2007), MHPSS interventions fall under four layers of interventions as shown in the figure below.

#### 5.2.1 DEFINING LAYERS OF MHPSS

---

\(^{36}\) Iraqi Penal Code 111 of 1969 as amended to 14 March 2010: Part 3, Chapter 1, Section 4, Article 417 and 418

\(^{37}\) Iraqi Penal Code 111 of 1969 as amended to 14 March 2010: Part 3, Chapter 1, Section 4, Article 417, sub-article 4.
Layer 1 - Basic services and security: The majority of people are represented in the bottom level of the pyramid. Most people recover their psychosocial well-being when basic physical security is established and they obtain the social, material (e.g., food and NFIs), communal and health services they need. The recommended way people in a helping profession can intervene is by ensuring that basic services and goods consider social and cultural factors and individual dignity.

- Who contributes MHPSS Layer 1: Security and state actors ensuring that people are residing far from active conflict and front lines; all clusters providing food, NFIs, health, education, livelihood opportunities, etc.; protection partners advocating for basic services to be met and documentation provided to access services like PDS.
- Basic services need to consult women and girls when planning response (e.g., contents of NFI kits address identified needs, health services consider if location is accessible for women and girls) and ensure their services reduce risks for women and girls (for example, lighting and locks on latrines and showers)

Layer 2 - Community and family supports: A smaller but still substantial number of people require extra support from their community and families to recover their psychosocial well-being, as shown in the second level of the pyramid. People in a helping profession can support by encouraging relevant traditional supports and social networks.

- Who contributes MHPSS Layer 2? Support and assistance with social re-integration, including vocational training and women’s empowerment, literacy training, school reintegration, child-friendly spaces, family tracing and reunification, women’s groups, youth clubs, parenting/family support, structured recreational and creative activities (like in women’s centers). Sharing information on available services and assistance within the community. Community and religious leaders facilitating conditions for indigenous traditional, spiritual or religious supports, including communal healing practices. Actors providing communal spaces/meetings to discuss, problem-solve and organize community members to respond to the emergency.

Layer 3 - Focused, non-specialized supports: A smaller number of people may need more focused services to regain their psychosocial well-being and protect their mental health, as shown in the third level. Such interventions include basic emotional and practical support, such as case management, provided by community-based workers or organizations.

- Who contributes to MHPSS Layer 3? GBV, CP and MHPSS actors who provide case management or use psychological first aid (PFA), as well as basic counseling for individuals, groups and families; psychoeducation about trauma, stress and emotional responses to conflict and displacement, and messages on positive coping and relaxation techniques

Layer 4 - Specialized services: For a very small percentage of people, the supports outlined above are not enough, and their mental health and ability to function productively depends on more specialized care. For these individuals, professional support is required from trained professionals, such as clinical psychologists (masters-level), psychotherapists and psychiatrists, who can provide more advanced mental health interventions (in-patient and out-patient).

5.2.2 WHEN TO REFER TO HIGHER-LEVEL MHPSS CARE:

- GBV case management can be considered a form of MHPSS, falling under the third level of the pyramid: focused, non-specialized MHPSS. It is also an important method for helping survivors access other mental health and psychosocial services, programs and resources in their community that are part of the other layers of the MHPSS pyramid. For example, GBV case management services can help survivors access basic needs (Layer 1) as well as reconnect with family and community support systems (Layer 2). In situations where it is determined that a survivor requires
a higher level of mental health care (fourth level), GBV case management services can facilitate a survivor’s access to such care.\textsuperscript{38}

- The vast majority of cases of GBV can be managed successfully by a caseworker or social worker who provides basic psychosocial support and case management.

- Caseworkers and social workers should be supervised and supported in a regular and structured manner to ensure they maintain the skills and confidence to handle most cases of GBV.

- Referrals to practitioners in Layer 4 Specialized Services should be made when:
  - Severe mental health conditions (psychosis, severe depression, etc.)
  - Cases with high risk (harm to self, to others)
  - Co-morbid with a medical condition
  - Nonresponse to basic support for about four weeks
  - History of psychiatric disorder or hospitalization in a psychiatric ward
  - Being on psychiatric medications

- Coordination between MHPSS actors should be made to ensure various MHPSS needs within different layers are met. For example:
  - Practitioners within Layer 4 Specialized Services play a role in referring patients to other layers of the pyramid. For example, a caseworker can continue working with a client even while she is seeing a psychiatrist so that the caseworker can help her meet her other needs (e.g., shelter).
  - Referrals can also be made to other services within the same layer, depending on the needs and wishes of the client. For example, a GBV survivor can be referred from individual counseling to group counseling offered by the same organization or another organization. A survivor can also be referred from one GBV caseworker (or CP caseworker) if they are more comfortable with the other organization.

### 5.2.3 PROVIDING EMOTIONAL SUPPORT:

- Listen to the survivor and ask only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press her/him for more information than she/he is ready to give.

- Be mindful of your body language, facial expressions, and tone of voice

- Squarely face your client: Adopt a bodily posture that indicates involvement with your client; a desk between you and your client may, for instance, create a psychological barrier between you.

- Have an open posture: Ask yourself to what degree your posture communicates openness and availability to the client. Crossed legs and crossed arms may be interpreted as diminished involvement with the client or even unavailability or remoteness, while an open posture can be a sign that you are open to the client and to what he or she has to say.

- Lean toward the client (when appropriate) to show your involvement and interest. To lean back from your client may convey the opposite message.

- Maintain eye contact with a client to show you are interested in what the client has to say. If you catch yourself looking away frequently, ask yourself why you are reluctant to get involved with this person or why you feel so uncomfortable in his or her presence.

- Don't fidget nervously or engage in distracting facial expressions. The client may begin to wonder what it is in himself or herself that makes you so nervous!

- Don’t tell the survivor that they must immediately forgive the perpetrator.

- Do not blame the survivor the violence she experienced. Use healing statements as mentioned in Chapter 4. Avoid asking questions that may imply blaming, such as “Didn’t you know that was a bad neighborhood?” Or “What were you doing out so late?”. Avoid asking “why” questions as they often make people feel defensive or like they are being blamed.

- Use open questions when possible. An open question is one in which you allow space for the person to respond fully (not just yes or no), thus giving the individual the freedom to disclose as much as they feel comfortable at the time.

- If the survivor expresses self-blame, care providers need to gently reassure him/her that sexual violence is always the fault of the perpetrator and never the fault of the survivor;

\textsuperscript{38} GBV AoR. \textit{Inter-Agency GBV Case Management Guidelines}. (2017)
• Give honest and complete information about services and facilities available;
• Prioritize safety at all times;
• Do not tell the survivor what to do, or what choices to make. Rather, empower him/her by helping him / her to make informed decisions.

Psychosocial supports for survivors of GBV should be holistic. They should target both people and communities (or aspects of both).

5.2.4 PSYCHOSOCIAL INTERVENTIONS FOR CHILD SURVIVORS:

• A comprehensive assessment to better understand the child’s social and family environment, Psychological wellbeing, and strengths to help determine appropriate psychosocial interventions;
• Providing healing education, relaxation training, teaching coping skills and problem solving
• Providing info to caregivers about the needs, care, and treatment of child survivors
• Identifying and providing support for families at risk of child mistreatment
• Psychosocial interventions should be adapted for child survivors and personnel providing support to child survivors should be trained accordingly.
• Facilitating groups for parents who have mistreated or are at risk of mistreating their children/adolescents

5.2.5 OTHER COMMUNITY-BASED PSYCHOSOCIAL ACTIVITIES

• Community-focused psychosocial interventions should seek to enhance survivor wellbeing by improving the overall recovery environment.
• This includes community awareness actions to reduce stigma and promote access to services for GBV survivors, strengthening of community and family support, including self-help and resilience initiatives.

5.2.6 MHPSS WORKERS SHOULD ALSO:

• Be trained on the effects of violence and displacement on children’s and adults’ psychosocial wellbeing and the signs of sexual abuse and other forms of GBV;
• Provide services in a way that promotes self-healing;
• Educate and support survivors and families throughout the care process
• Identify strengths and needs to engage the survivor and family in a strength-based care and treatment process
• Include non-offending caregivers in the process
• Help arrange appointments with other partners to ensure needs are met and advocate on consented behalf of survivor for services, and accompany survivor when requested
• Involve the affected community in the planning and carrying out of GBV and psychosocial activities;
• Keep all files, data and information confidential and secure

5.3 SECURITY AND SAFETY RESPONSE

The safety and security of survivors should always be prioritized. Caseworkers may, upon receiving a case:

• Work with survivors to explore options and strategies to stay with or leave their family, when appropriate and according to her choices and wishes, always prioritizing safety;
• Provide a phone or phone credit so that the survivor may be in contact with the case manager in cases when the survivor is not reachable. This should only be done when providing a phone or credit will not put the survivor more at risk;
• Provide the hotline number to be used in case of emergency;
• Provide interim alternative accommodation, pending long-term options, providing financial support and transport to the safe location whenever possible. Always assess the security risks related to this option and ensure ongoing monitoring of protection risks
Security/safety concerns may be addressed by camp security personnel, neighborhood watch teams, police, DCVAW, Asayesh and/or the military responsible for security. These actors need to be identified and have clearly delineated responsibilities. In addition, communities must understand how to contact security personnel for help with safety, security, and protection. Security/safety actors should:

- Encourage community to report threats and help women coordinate solutions, such as patrols. Community needs to know that security personnel are there to help in cases of GBV.
- Explain to community the reason for presence of armed personnel in certain situations, such as patrols.
- Have female personnel to receive reports of GBV and risks for women and girls, intervene with survivors in police station and during the transportation of the survivor.
- Provide a secure and private environment for speaking with the survivor/family.
- Be readily available to listen to the concerns of the GBV survivor and receive the survivor with compassion and accept the survivor’s story without passing judgement.
- Follow informed consent procedures according to local laws and age of survivor.
- Inform survivor of other available services that meet her stated health, legal, safety, and psychosocial needs, ensuring the survivor understands the benefits and consequences of seeking help from other service providers. Refer the survivor as needed according to her wishes.
- Be familiar with the basic principles and practice of the legal system and obligations of those within the system, especially their own and those of the health sector.
- Uphold the client’s privacy and confidentiality.
- Reliably document the case and take necessary measures to ensure her information is kept completely confidential and safe.
- Follow leads and be willing to press charges in a professional and appropriate manner.
- Provide expert statements, reports, and testimony for the courts.
- Ensure the survivor is physically safe through various means (patrol, accompaniment, safe shelter/house).

See Section 5.4.2 on Police Procedures for Reports of GBV-Related Crimes for more information on procedures and timelines for receiving complaints, investigating crimes, arresting and detaining alleged perpetrators and filing charges with the court.

5.3.1 SAFE SHELTER

Government-run shelters for safety options for survivors in KRI operate under article 7 item 3 in the Ministry of Social Affairs law No. 12 of 2007;

- While community-based solutions to a survivor’s safety are often best placed to address her immediate and long-term needs, particularly life-threatening cases may require referral to a safe shelter. Actors need to consider that the decision to refer to a safe shelter could further isolate the survivor.
- Referrals to shelters should ideally be made when there is a clear strategy and case management plan leading towards a longer-term solution;
- When necessary, the referral agency will ensure follow-up on the case referred;
- When necessary, the referral agency will follow-up on necessary measures and actions including social welfare, medical, and psychosocial services;

There are government-run shelters in KRI. Any service provider can refer a case to DCVAW in order to receive shelter in the government-run shelter using the standard and following MoLSA – GDCVAW criteria guidelines.

Note Before: DoLSA should notify UNHCR in case of refugee admitted into the shelters.

---

39 1- 2005, Iraqi constitution five, chapters 29, 37, 45. (Shelter related)
2- Act of labor and social affairs ministry number 12, 2007. (Shelter related)
3- Act of combating domestic violence. Number (8) 2011. (Shelter related)
5.3.6 TRAINING AND CAPACITY BUILDING WITH SECURITY ACTORS

Security personnel must be trained for their work and understand any limitations of their roles. Security actors must also receive training on:

- Prevention of and response to GBV, including the guiding principles; human rights and women’s rights; and codes of conduct (prohibition of sexual exploitation and abuse).
- Practical scenarios, starting with the practical and then moving to the conceptual, rather than the reverse. Instead of teaching theoretical content about sex and gender, training should equip uniformed security personnel to meet these challenges in the field.
- Responding appropriately to gender-based security threats, rather than being limited to cultivating awareness on the prevention of sexual exploitation and abuse, which are necessary but not oriented to prepare personnel to address patterns of sexual violence, especially when used by armed groups. Responding to widespread or systematic sexual violence should be part of rehearsal exercises, scenario-based training, and in-mission refresher courses.
- Understanding that many GBV survivors do not want intervention from security actors.
- How to maintain awareness of gender-based security issues in the setting, especially those that specifically affect women and girls.
- Treating and talking to survivors with dignity and compassion.

5.4 LEGAL/JUSTICE RESPONSE

5.4.1 LEGAL OPTIONS

Legal responses include providing legal counseling, assistance, and representation for adults and children, when the survivor wants to press charges against the perpetrator or in cases related to personal status (e.g. custody law issues, divorce, alimony, etc.). This includes:

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

Legal service providers may also offer non-GBV-related services, such as support in obtaining missing documentation.

5.4.2 POLICE PROCEDURES FOR REPORTS OF GBV-RELATED CRIMES

In KRI, cases of GBV that involve violence in the family against children and women can be referred to DCVAW with survivor consent or following mandatory reporting procedures if the survivor wishes to take legal action against the perpetrator (i.e., bring criminal charges against the perpetrator). For cases that do not involve domestic violence, the local police handles the investigation and procedures. For cases involving asylum seekers or refugees, a GBV survivor or their caregiver can report directly to DCVAW – in this case when the survivor/caregiver consents, DCVAW will inform UNHCR.
The Act of Combating Domestic Violence in Kurdistan Region-Iraq (No. 8, 2011) defines domestic violence as “Every act and speech or threat of doing so based on gender within family relationships constituted on marriage or blood to the fourth degree or whoever if legally included in the family, which may harm an individual physically, sexually and psychologically and deprive his/her freedom and liberties”. Under this definition, DCVAW is mandated for handling criminal cases (e.g., forced and early marriage, FGM, forced divorce, disowning family members, husband forcing wife into sex work, forcing family members to unwillingly quit their jobs, forcing children to work and drop out of school, suicide due to domestic violence, abortion due to domestic violence, battering of family members, and marital rape). All other cases are referred to the local police, including GBV committed by an intimate partner not related by marriage.

When a complaint is received by DCVAW in camps/units in the cities, procedures are as follows:

- Priority is given to medical treatment when deemed necessary prior to interviewing the survivor;
- Interviews with the survivor take place in private settings with an officer of the same sex or as preferred by the survivor;
- Cases are handled with extreme confidentiality and DCVAW has a coding system in place for such purposes;
- Obtain the informed consent of the survivor. In the case of rape, it is of outmost importance that the survivor receives lifesaving medical services as a first priority (CMR protocol Iraq 2017), with consent from the survivor, DCVAW staff can report and present the case to the judge who will decide to request a forensic report.
- The forensic doctor at the main hospital collect and seal forensic evidence samples, send them to the laboratory, and issues a forensic report;
- The police visit the scene of the incident if and when necessary to gather evidence to be sent to the laboratory. In cases when more than 24 hours have passed after the incident, physical evidence of the crime cannot be obtained;
- A case file is opened and all relevant documents are processed and sent to the judiciary if/when necessary (see below for details);
- Temporary protection is provided to the survivor or other family members during the period of investigation if and when necessary;
- Follow-up on the wellbeing of the survivor ensuring access to social welfare, medical, forensic and psychosocial services;
- Detain the alleged perpetrator;
- Ensure spatial and qualitative evidence;
- Document the complaint in the registry;
- Consult with the forensic doctor at all times;

DCVAW mobile teams exist in some locations. These teams do not conduct a detailed investigation but include the initial information and refer the case to the DCVAW offices for further action.

As the Asayish has primary responsibility for all security-related matters in their respective governorates, DCVAW may refer cases of violence involving matters of broader security such as conflicts between clans or families or honor crimes to the judge.

Specific DCVAW procedures vary according to both the type of violence, and whether the survivor is an adult or child, as described below. In all cases, the following basic initial steps are conducted:

Step 1: all cases are first assessed by the officer who is the head of the DCVAW branch at the location; who will determine whether the case needs to be referred to medical support, PSS (ie. to a social worker) or mediation to the social worker.

Step 2: if the survivor needs medical or PSS then they will refer the case for medical support or the social worker for PSS or mediation in her case to also the social worker.

Step 3: if the case does not need medical or PSS then the officer provides the option to the survivors whether they want to file a complaint against the perpetrator/file judicial complaint (court proceedings).
Step 4: if the survivor does not want to take her case to the courts then she can ask to have the perpetrator sign a guarantor to not cause her any further harm and if there is violation of the guarantor then the perpetrator will be subject to arrest.

Physical assault or sexual assault against adults and children (felonies):

- In cases of felonies, the survivor (or their caregiver) can decide whether they wish to file a complaint or not against the alleged perpetrator. If they wish to file a complaint, then the judicial proceeding described below will be followed;
- If they do not wish to file a complaint, DCVAW will still refer the case to the public prosecutor who will decide whether or not to refer the case to the court proceedings. In this case, their statement can be used by the public prosecutor and they may be called to testify;
- As such, all cases of physical assault against women and children perpetrated by family member are referred by DCVAW to the public prosecutor.

Minor physical assault (i.e., causes a minor injury which leaves no trace on the survivor's body) against adults perpetrated by a family member that does not constitute major physical assault (misdemeanor; e.g., causes them to be harmed or contract an illness, broken bones, leaves traces on the survivor's body, etc.):

- DCVAW is mandated to report major physical assault to the judiciary.
- The investigator counsels the survivor on the following three options: a) Press charges against the alleged perpetrator/file a judicial complaint (court proceedings); b) Refer to a social worker for family mediation; c) Refer to the judge to have the alleged perpetrator sign a pledge not to abuse the survivor again;
- The survivor decides which option she/he wishes to pursue. If the survivor does not want to press charges, the survivor is referred to the judge. If the survivor again decides she/he does not want to press charges, then the case is closed.

### 5.4.3 Judicial Procedures

**Kurdistan Region** According to KRG Domestic Violence law, “The procedures pertaining to investigation and trial in cases of domestic violence remain confidential.” Service providers should advocate for closed-door trials and sessions for all GBV survivors.

Given the sensitivity of cases of sexual violence, judicial procedures are different from those for physical violence, in that hearings are always conducted in private sessions and chambers in the courtroom. Extra protection and security measures are put in place during the hearing to ensure the safety of the survivor.

Courts exist for investigating domestic violence cases in Erbil, Dohuk, Sulaymaniyah and Garmian. For areas outside these cities, this task is carried out by the District Investigation Courts in addition to their regular functions. The court may issue a Protection Order if necessary or when requested by a family member or who represents him/her for a determined duration for protection purposes. The survivor may waive her right to a Protection Order and the court will determine if the waiver is according to her willingness. The order includes a pledge from the perpetrator to not stand against the survivor or her family members and to not enter the family house for a duration determined by the court when there is a risk to the survivor or family members. If the Protection Order is violated, the offender is imprisoned for no more than 48 hours or pays a fine.  

In KRG, the court may refer parties to a lawsuit to a formal Reconciliation Committee comprised of at least a judge, imam and lawyer to attempt to reconcile the case before having a court decide on a case. Reconciliation is not obligatory; however, it is considered one of the conditions of referral of the case to the court of subject according to the legal article No. 5 in Law No. 8 of 2011. Reconciliation Committees exist in Erbil, Dohuk, Sulaymaniyah and Garmian area.

---

40 KRG Act 8 from 2011 “The Act on Combating Domestic Violence in Kurdistan Region - Iraq”
5.4.4 TRADITIONAL JUSTICE MECHANISMS

In KRI, there is no law in place that established traditional justice mechanisms and the court not obliged to implement decisions made by informal traditional justice forum. However, conscious, careful, and respectful attention can be given to such mechanisms by:

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

Mediation is a process that is frequently used in customary law to solve disputes between community members, families and family members. Cases of IPV and domestic violence are sometimes ‘settled’ by traditional or religious leaders, as it is considered a private family matter. **In general, mediation is not recommended as a response to IPV because of the safety risks that it poses for the survivor.** Survivors seeking help from organizations responding to GBV may want their cases to be handled through mediation because they want the violence to stop and may perceive mediation as a way to facilitate this. In some cases they may request that social workers carry out the mediation. Therefore, it is important that organizations have clear guidelines on how to respond to these requests in a way that is survivor-centered. Mediation is not a recommended response for most GBV cases because it is unlikely to stop the violence from happening in the long term and it has the potential to escalate violence, causing more harm to the survivor.

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

5.4.5 TRAFFICKING IN PERSONS

Many of the causes of gender inequality and GBV are also driving forces for trafficking in persons, resulting in the two concerns being closely interrelated. Within crises these factors are exacerbated by the erosion of rule of law and protection structures, increased criminal networks, and reduced economic opportunities, which can all lead to heightened vulnerability to trafficking for refugees, IDPs, host communities and migrants. Trafficking in persons refers to the exploitation of human beings as a commodity, and in relation to GBV encompasses a range of exploitative practices such as sexual slavery and exploitation, domestic servitude, and forms of forced and early marriage. Whilst women and girls are often viewed as most vulnerable to trafficking, men and boys are also targeted and exploited by traffickers, mainly for labor exploitation and forced recruitment.

---

If an individual is suspected to be a survivor of trafficking (and have provided their informed consent), they should be referred to an experienced service provider for a trafficking screening assessment to identify their needs and determine their status so that they may receive specialized assistance. Possible assistance may include:

- Screening of an individual to determine Victim of Trafficking (VoT) status; assessment of immediate needs such as shelter, health, etc.;
- Risk assessments (individual and situational assessments relating to the area/country in which they have been identified/ will be initially supported) to inform assistance approaches;
- Coordination with law enforcement agencies as required including supporting access to justice
- If they are international or domestic, then an assessment should be done to determine whether they can return to location/country of origin, if not then alternative arrangements would need to made;
- If return is possible and safe then a return and reintegration (individual and situational) assessment would be conducted also identifying risk in relation to the return/reintegration process;
- Development of a reintegration plan and coordination with trafficking/protection stakeholders in location/country of origin to ensure arrangements made for the implementation of the plan (as coordinated with survivor).
- Arrangement of travel procedures and coordination with receiving (reintegration) organisations to provide arrival assistance.
- For international survivors then coordination with embassies, arrangement for travel documents, coordination with law enforcement to arrange return procedures (in Iraq for international survivors often extensive liaison is required with Ministry of Interior (MoI) and Airport authorities);

As trafficking in persons can involve organized criminal networks, there is a potential level of risk to which survivors of trafficking and service delivery personnel who support them may become exposed to, therefore a risk assessment should be completed from the beginning of the assistance process (and continue throughout case-management). The risk assessment should be conducted by an agency that is familiar with the risks that a VoT might face. Potential risks to identify could include:

- Psychological and physical condition that would create risks or special needs during her/his travel, initial reception or possible admission into a rehabilitation center;
- Any indications that the trafficker(s) knows:
  - The current residence of the individual
  - That the individual is being assisted by your agency
  - The location of the individual's family or other closely related persons or has been in contact with them
  - Or suspects the VoT was in contact or cooperation with law enforcement
- Contact between the trafficker(s) and the individual since the time of rescue/escape in the place/country of destination
- Any of the individual’s family members or other closely related persons implicated in the trafficking process
- Contact or cooperation with any law enforcement agency in the (last) place/ country of destination
- Police taking or planning to take any action against the trafficker(s) in the destination place/country or in the receiving place/country

A high-risk case would include a clear indication that the VoT has already cooperated with law enforcement agencies and provided information or evidence; and/or the trafficker either knows or believes that the VoT has cooperated with the police.

Service delivery organizations assisting survivors of trafficking should ensure protection principles are adhered to, and that access to justice and direct assistance to survivors of trafficking is based on the United Nations Palermo Protocol and survivor-centered best practice as outlined elsewhere in this document. Following a risk and screening assessment, relevant service providers (IOM for foreign national VoT; qualified protection actors for Iraqi VoT) should also conduct a reintegration assessment based on both individual and situational factors, resulting in the development of a comprehensive reintegration plan (in coordination with the receiving service delivery organization) that is responsive to the specific wants and needs of the survivor, and their circumstances and status within Iraq. In cases of survivors who are not
citizens of Iraq, relevant service delivery organizations as outlined below should be contacted to provide international return and reintegration assistance (as required).

<table>
<thead>
<tr>
<th>Location</th>
<th>Organization</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anywhere in Iraq</td>
<td>International Organization for Migration (IOM)</td>
<td>Direct assistance, international/domestic reintegration support</td>
</tr>
</tbody>
</table>

**CHAPTER 6. CASE MANAGEMENT**

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

The basic principles that underpin case management include:

- Ensuring the survivor is the primary actor in case management;
- Empowering the survivor and ensuring that he/she is involved in all aspects of the planning and service delivery;
- Respecting the wishes, the rights, dignity needs and capacity of the survivor;
- Providing emotional support by demonstrating a caring attitude towards the survivor;
- Providing information to the survivor to allow him/her make informed choices about services requested;
- Listening and establishing rapport and a trusting relationship, which creates a supportive environment in which the survivor can begin to heal;
- Ensuring confidentiality which is critical to protecting the survivor’s safety and security and to prevent misuse of information, explain clearly to survivor the exceptions as to when confidentiality may be breached;
- Ensuring non-discrimination by treating every survivor in a dignified manner irrespective of his/ her sex, background, race, ethnicity or circumstances of the incident(s);
- Obtaining informed consent from the survivor prior to sharing any information.

As mentioned above, the goal of case management for GBV survivors is to empower him/her by giving increased awareness of choices and support in taking informed decisions, raising awareness of the services that are available. Case management for GBV survivors is focused primarily on meeting the survivor’s health, safety, psychosocial and legal needs following the incident(s).

Case management for GBV cases is provided by the agencies listed in the annex. These agencies will assess any GBV case they receive or that is referred to them for support.

**6.1 RESPONSIBILITIES OF CASEWORKERS AND AGENCIES**

Caseworkers, social workers and case managers must have the skills to manage cases in line with the above principles, an understanding of their roles and responsibilities, and an ability to handle difficult situations professionally and with cultural sensitivity.

The case management agencies are responsible for staffing, supervising and monitoring GBV case management service provision to ensure guiding principles and a survivor-centered approach are used, best practices are met, all available referral services are mapped, gaps are identified, barriers to accessing

---

43 See Chapter 3 of the Interagency GBV Case Management Guidelines (2017), which outlines the minimum qualities, skills and knowledge of GBV caseworkers.
services are addressed and advocated for, services are coordinated with other actors, and full case management services are provided, including follow-up. Appropriately staffing a case management service is essential for quality of care. In Iraq, it is recommended that:

- A GBV case management agency has enough GBV caseworkers to allow for a caseworker-to-survivor ratio of 1:15 active cases, at the most 1:20. This should be monitored very closely by supervisors with the understanding that some cases require greater involvement depending on the needs and circumstances of the survivor and the stage of the case in the case management process.
- Caseworkers speak the language(s) spoken by survivors so survivors can communicate in their first language.
- The gender of caseworkers should be considered. For example, for program that are established to specifically address violence against women and girls and where the entry point for case management services is a women’s centre, female caseworkers should be hired in order to keep the women’s centres ‘women-only’, to protect the emotional and physical safety of the survivors. In other cases, it may be beneficial to have a mix of female and male caseworkers. These decisions should be based on the context, the types of GBV and your organization’s or program’s focus.
- The ethnic, religious and cultural background of caseworkers should also be considered, and caseworkers should be hired to create a staff mix that is proportional to the makeup of the population being served.
- A supervisor to caseworker ratio of 1:5 and no larger than 1:8.
- Ongoing training, learning, support and other capacity building opportunities for caseworkers to further develop core qualities and skills and for supervisors to advance their technical and management abilities.

6.2 STAFF CARE

Supervisors and organizations play a critical role in creating an organizational culture that prioritizes the safety and well-being of its staff. This is particularly critical for organizations that are providing GBV services in humanitarian settings given the exposure of staff to highly stressful situations and the risk of vicarious (also known as secondary) trauma. We often talk about “self-care” in our work—or what an individual can do to prevent stress from becoming overwhelming. On a personal level, not practicing good self-care can lead to physical, emotional, mental and spiritual harm. It can disrupt overall well-being, quality of life and personal relationships. While the emphasis of self-care is usually on the individual, self-care is important for individuals and organizations as productivity and work often suffer when good self-care is not promoted and encouraged by supervisors and individuals alike. For these reasons, organizations, particularly those responding to difficult issues such as GBV, also have a responsibility to provide a level of care for their staff.

Caseworkers are often the people working closest with survivors, hearing their experiences of GBV, and responding with care, compassion, and concern. Over time, without appropriate support and supervision, caseworkers may begin to feel overwhelmed and tired, and may even begin to feel hopeless and helpless. In order to prevent caseworker burn-out and to facilitate caseworkers’ capacity to provide the best care and services to survivors, supervisors (and organizations) need to make explicit a commitment to staff well-being and implement specific strategies for promoting it. While every organization will need to develop its own strategies and approaches for staff care based on resources and structure, below are basic tips for how supervisors can promote the care of GBV casework staff.

Facilitating everyday staff care

- Create a supportive climate – regularly check on the well-being of staff, create an environment where staff feel comfortable sharing information and concerns with you.
- Establish routines – including for supervision and team meetings.
- Regularly demonstrate appreciation for staff. This can be as simple as communicating gratitude or praise for something they did or arranging to have refreshments at meetings to something more elaborate such as a “staff of the month” award.
- Manage information – Routinely share information and create an environment of transparency.
- Monitor the health and well-being of staff. For example, be mindful of how staff are taking care of themselves and encourage them to take lunch breaks, etc., and take note of changes in appearance or health.
- Monitor stress levels – support staff to identify and monitor stressors in their lives and to develop self-care plans.
- Provide opportunities for exercise and access to the outdoors.
- Organize “staff care” days that allow staff to come together to do something fun or relaxing.
- Encourage staff to identify a “self-care buddy” – another staff person with whom they connect on a regular basis to discuss how they are and what support they need from each other.
- Accommodate staff – be flexible with the response of different individuals to personal or work crises (e.g. allow flexible schedules if possible, give time off where needed, provide additional supervision, etc.)

Providing support for staff in crisis
- When staff are in crisis either because of a professional or personal experience that may be impacting their work, the following may be important:
  - Create opportunities for staff to share experiences and stressors (e.g. through supervision)
  - Watch for caseworkers who may be suffering in silence and actively reach out to them.
  - Connect them to psychological support – if available in the context, connect staff to mental health professionals on a regular basis.

6.3 STEPS OF CASE MANAGEMENT

- Introduction and Engagement;
- Assessment;
- Case Action Planning
- Implementing the Case Action Plan
- Case Follow-Up
- Case Closure
- Service Evaluation

The Iraq GBV SOPs will follow the global GBV Case Management Guidelines (2017), which set standards for quality, compassionate care for GBV survivors in humanitarian settings. Please reference this resource for more in-depth information on the steps of case management.

6.4 CASE CONFERENCES

Caseworks act as a liaison between the survivor and service providers, advocate for timely and quality care for the survivor, and work with service providers to reduce obstacles to accessing services. This requires regular communication and follow-up with other actors working with a survivor. One aspect of case coordination is case conferencing.

Case conferencing is a planned, structured meeting convened by the caseworker to discuss a particular case with other service providers involved in the survivor’s care and treatment. Case conferences allow the caseworker to:

1) review activities, including progress and barriers towards goals;
2) map roles and responsibilities;
3) resolve conflicts and strategize solutions;
4) adjust current action plans.

Case conferences can be effective venues for addressing any problems with services not being provided in a timely way, or to get clarity on who is doing what to avoid duplication of efforts in complex cases involving
many actors. Case conferencing is done on an ad hoc basis and is distinct from ongoing service coordination and other coordination forums.

Getting the survivor’s consent is a crucial prerequisite for any case conference. The survivor must consent to information sharing with each participant service provider in the case conference. If consent has not been given, then the individual case must not be discussed. Service providers may participate in case conferences by invitation only and should only include actors who are providing care to the survivor (or potential service providers) and who receive consent from the survivor to receive/share information. The information shared at this conference is strictly confidential and will focus on actions taken and actions needed. Information sharing must only include relevant information and should not include irrelevant personal or other details about the survivor or the incident. A survivor has the choice to be present in the case conference and has the right to limit what information is shared.

Detailed notes and action points from the case conference should be taken by the caseworker and stored in the case file using a survivor code, not name or other identifying information.

Please note that case review meetings are separate from case conferencing. Case review meetings are internal meetings as part of case supervision between the caseworker and her supervisor, and does not involve other agencies.

- All members of this meeting are responsible for ensuring that the dignity and confidentiality of survivors are maintained and that information discussed is only that which is needed to resolve problems and coordinate actions;
- It is the responsibility of the designated case managers for each case discussed to ensure that information sharing has been duly pre-authorized by the survivor. The case manager also keeps the survivor informed of decisions and progress made.

**6.5 CASE CLOSURE AND PROJECT CLOSURE**

In general, caseworkers can close a case as follows (and fill Case Closure form):

- Do not include consent forms in closed case files. Like active files, these should be stored separately. Consent and case forms should be stored safely in locked filing cabinets.
- Good practice when a project closes is for the service provider to:
  - Offer clients to transfer their care to another service provider, if available. The caseworker can brief the new service provider about the case and accompany the client to their first meeting.
  - Offer clients to transfer their case file to the other service provider. Again, the survivor can choose what information, if any, to transfer. An alternative is that the caseworker just verbally briefs the new service provider of the basics of the case.
  - If the survivor declines transfer to another service provider, destroy with the consent all printed material by shredding or burning (if safe to do so) followed by pulping (i.e., adding water to shredded paper or ashes to further destroy any remaining material). This renders the information completely unreadable. Service providers have non-identifiable GBVIMS data in the soft copy Incident Recorder for anything in the future.
- Actors that are not involved in the direct care of the survivor and do not have explicit survivor consent to receive case information should never contact clients of a service provider. This risks re-traumatization of a survivor, breaches confidentiality, and may constitute a breach of the GBVIMS: “All signatories agree that the GBVIMS data will not be used for following up on individual cases”

**6.6 MEDIATION**
Organizations providing services to GBV survivors should have a clear policy on mediation. The policy should state that GBV caseworkers should not carry out mediation or any similar practices that involve working with the survivor and perpetrator together.

In addition, some caseworkers may determine that it is not safe for them to provide advocacy support for a survivor who is going through a mediation process (i.e. liaising with community or family members involved in the mediation). They may know the perpetrator, perpetrator’s family or the mediator and thus be worried about their own and their family’s safety. Supervisors should support caseworkers in prioritizing their safety and work with the survivor to provide alternative options (e.g. identify someone else who can help).

Please refer to Chapters 1.4 and 1.6 of the Interagency GBV Case Management Guidelines for more information on how to approach mediation in cases of IPV, risks involved, the caseworker’s role and the organization’s role.

**6.7 CONSENT FOR CASE MANAGEMENT WITH CHILDREN**

In general, permission to proceed with case management (and other case actions) should be obtained from the child, as well as the caregiver or another suitable adult (see below).

<table>
<thead>
<tr>
<th>Age group</th>
<th>Child</th>
<th>Caregiver</th>
<th>If no caregiver or not in child’s best interest</th>
<th>Means</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-11</td>
<td>Informed assent</td>
<td>Informed consent</td>
<td>Other trusted adult’s or caseworker’s informed consent</td>
<td>Oral assent, written consent</td>
</tr>
<tr>
<td>12-14</td>
<td>Informed assent</td>
<td>Informed consent</td>
<td>Other trusted adult’s or child’s informed assent. Sufficient level of maturity (of the child) can take due weight</td>
<td>Written assent, written consent</td>
</tr>
<tr>
<td>15-17</td>
<td>Informed consent</td>
<td>Informed consent with child’s permission</td>
<td>Child’s informed consent and sufficient level of maturity takes due weight</td>
<td>Written consent</td>
</tr>
</tbody>
</table>

- In the Kurdistan Region of Iraq, parent/caregiver’s (or other responsible adult’s) legal consent should always be obtained for children under 18 years of age. For children 15-17 years old, child’s informed consent may be obtained instead of the caregivers if the parent/caregiver is not able or willing to provide consent;
- For younger children, their informed assent or willingness to participate should be provided, while for older children informed consent should be requested (see below for details);
- There may be cases in which it is not appropriate to obtain parent/caregiver consent, including where the caregiver may be the perpetrator or complicit in the abuse, or where unaccompanied children are involved. In such cases, wherever possible the consent of another trusted adult should always be sought for children under 16. For children above 6, they should participate in identifying this person. Where such person is not available, the case manager may have to provide consent for children under 16;
- Children and caregivers should be made aware of any relevant mandatory reporting requirements (see section on mandatory reporting).

**6.6.1 INFANTS AND TODDLERS (AGES 0–5):**

---

Informed consent for children in this age range should be sought from the child’s caregiver or another trusted adult in the child’s life, not from the child. Very young children are not sufficiently capable of making decisions about care and treatment. The service provider should still seek to explain to the child all that is happening in very basic and appropriate ways.

6.6.2 YOUNGER CHILDREN (AGES 6–11):

- Typically, children in this age range are neither legally able nor sufficiently mature enough to provide their informed consent for participating in services. However, they are able to provide their informed assent or willingness to participate.
- Children in this age range should be asked their permission to proceed with services and actions, which affect them directly. This permission can be provided orally by the child and documented as such on the informed consent form. For children in this age range, written parent/caregiver informed consent is required, along with the child’s informed assent.

6.6.3 YOUNGER ADOLESCENTS (AGES 12–14):

- Children in this age range have growing capacities and more advanced cognitive development, and may be mature enough to make decisions and provide informed assent and/or consent for continuing with services.
- According to standard practice, the caseworker should seek the child’s written informed assent to participate in services, as well as the parent/caregiver’s written consent.
- However, if it is deemed unsafe and/or not in the child’s best interest to involve the caregiver, the caseworker should try to identify another trusted adult in the child’s life to provide informed consent, along with the child’s written assent. If this is not possible, a child’s informed assent may carry due weight, if the caseworker assesses the child to be mature enough. In these situations, caseworkers should consult with their supervisors for guidance.

6.6.4 OLDER ADOLESCENTS (AGES 15–17):

- Older adolescents, ages 15 years and above, are generally considered mature enough to make decisions. In addition, in KRI / Iraq18-year-olds are legally allowed to make decisions about their own care and treatment, especially for social and reproductive health care services.
- Older adolescents can give their informed assent in accordance with local laws. Ideally, supportive and non-offending caregivers are also included in care and treatment decision-making from the outset and provide their informed consent as well.

However, decisions for involving caregivers should be made with the child directly in accordance with local laws and policies. If the adolescent (and caregiver) agrees to proceed, the caseworker documents their informed consent using a client consent form or documenting on the case record that they have obtained verbal consent to proceed with case management services.

CHAPTER 7. RESPONSIBILITIES FOR PREVENTION

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. Prevention activities are aimed at potential perpetrators, potential survivors, and those who may assist them. Activities must therefore target the affected community, humanitarian aid staff, host country nationals, and government authorities. Prevention also includes more generalized approaches for the population at large (e.g. campaigns, mass media messaging and other awareness-raising initiatives).
All parties to these SOPs will:

- Provide or participate in training about GBV, the IASC GBV Guidelines, these SOPs, and other relevant materials, adapted to the sector of intervention;
- Adopt codes of conduct for all staff that focus on preventing sexual exploitation and abuse. Actions include: providing training to all staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow-up on reports;
- Actively seek equal participation of women, girls, boys, and men in the design and delivery of services and facilities in the setting, and meeting regularly with women and girls to learn about accessibility, safety, and security related to services and facilities;
- Ensure services are inclusive and accessible for persons with disabilities;
- In collaboration with the GBV sub-working group, carefully coordinate, develop and implement GBV awareness-raising activities within the community and advocacy among other humanitarian actors and government authorities;
- Organize economic empowerment activities to reduce vulnerabilities;
- Strengthen the protective environment, by assessing security and safety and addressing protection issues. When designing projects and implementing interventions, always consider intended and unintended consequences of activities and review strategies to ensure survivor’s protection and according to the best interests of the survivor(s);
- Foster community mobilization and outreach information campaigns to prevent further incidence of the identified violence and stigmatization of survivors. Agencies should work with All communities including refugee, IDP and host population to:
  - Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described in these SOPs and the IASC GBV Guidelines including:
  - Carry out campaigns, mass media messaging and other awareness-raising initiatives);
  - Maintain awareness of GBV risks and issues in the setting, and communicate these to security actors and the GBV working group;
  - Engage in problem-solving discussions to continuously strengthen prevention strategies
  - Actively promote respect for human rights and women’s rights, and support the role of women and youths as equal decision makers;
  - Promote male role models and positive masculine norms and behaviors that are non-violent.

7.1 PREVENTION AND RISK MITIGATION FOR GBV SERVICE PROVIDERS

Preventing GBV means identifying and removing those factors that make certain members of the local community vulnerable to violence and designing activities that improve their protection. To prevent gender-based violence, GBV causes and contributing factors in a given context should be identified, understood, and addressed.

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 violence against women and girls and GBV.
In order to achieve this, GBV actors should at the outset:

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

The following protection framework is addressed to GBV actors and contains general recommendations to set up a prevention intervention. The list of activities is not exhaustive and should be contextualised according to locations within the Kurdistan Region of Iraq (KR-I), the risks involved, and the expertise of the GBV actors.

**PHASE 1. IDENTIFY CONCERNS AND RISKS** This phase aims at understanding the local attitudes towards and practices of gender roles and discrimination, through specific assessments, and above all the situation-specific factors that contribute to or increase the risks for GBV in a given area.

- Carry out safety audits on a regular basis and use them to inform actions and programming.
- Carry out participatory assessments with women and girls to understand their issues and concerns.
- Involve women and girls in planning and decision-making to fully address their safety and security concerns through evaluation exercises.
- Set up feedback and community complaints mechanisms to inform your program on specific issues and concerns.

**PHASE 2. RAISE AWARENESS AND SHARE INFORMATION** The awareness phase is about increasing the community’s understanding about gender roles, human (and women) rights, gender-based violence causes and consequences, and services available to GBV survivors in order to promote social change and increasing awareness amongst women and girls on where to seek help.

- Promote harmonization of Information Education Communication material, encourage use of creativity to stimulate discussion in groups, stimulate critical thinking rather than to telling people what to think.
- Ensure all IEC material or key messages have been pre-tested with communities first to ensure their feedback is included and to ensure no further harm is caused.
- Strengthen women, girls, men and boy’s understanding of gender-based violence issues using interactive and thought-provoking exercises and roles plays to challenge myths and stereotypes around women’s and men’s roles.
- Facilitate focus groups discussions, campaigns, door-to-door visits addressing specific topics according to the age, sex, nature/type of audience. Topics should be selected based on the previous risk identification.
- Facilitate specialized training for health care providers, psychosocial actors, women’s groups, community leaders, local authorities (if appropriate), other humanitarian agencies, school personnel, parents’ associations on GBV core concepts, GBV guiding principles, and IASC GBV Guidelines.
- Ensure that all staff and implementing partners are informed and aware of the zero tolerance policy on SEA as highlighted in the SG Bulletin 2003.

---

45 Immediate prevention of Sexual Exploitation and Abuse (SEA) involves the following minimum actions: Screening job applicants and recruiting staff who will not perpetrate sexual exploitation and abuse; Ensuring that all actors understand the definition of sexual exploitation and abuse, expected standards of behavior, and their obligation to prevent SEA; Putting systems in place to respond to allegations, enforce codes of conduct and standards, and ensure there are consequences for those who perpetrate SEA; Educating communities on their entitlements and rights, the zero tolerance approach to sexual exploitation and abuse, and how to report complaints; Decreasing the vulnerability of those at higher risk of SEA through ensuring access to resources to meet basic needs and implementing livelihood programs.
PHASE 3. TAKE ACTION AND EMPOWER

This phase aims at translating awareness and knowledge acquired in the previous phase into practice. During this phase individuals and groups can create change. In this phase GBV actors should engage even more people from all circles of influence and reach a critical mass for changing community norms.

- Build networks among community groups, associations and enhance collaboration and coordination among them.
- Empower women and girls through specific age tailored activities in order to engage them in the community life, build safety nets and promoting their resilience.
- Meet the basic needs of women and girls, through the distribution of non-food items (NFI) and age-tailored dignity kits, access to livelihood opportunities.
- Advocate on behalf of civilian communities for protection from gender-based violence and raise funds for GBV programming.
- Set up safe spaces and age-tailored women and girls’ activities whereby they can feel confident and safe to share concerns and risks.

Box 5. Women and Girls Safe Spaces

A safe space is a formal or informal place where women and girls feel physically and emotionally safe. The term ‘safe,’ in the present context, refers to the absence of trauma, excessive stress, violence (or fear of violence), or abuse. It is a space where women and girls, being the intended beneficiaries, feel comfortable and enjoy the freedom to express themselves without the fear of judgment or harm. Safe spaces 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. These spaces may take different names such as women centers, women community centers, or listening and counseling centers, to name a few. Women safe spaces are not the same as shelters or safe spaces at reception centers or one-stop centers.

Prevention and Risk Mitigation for Other Humanitarian Sectors

The responsibility for preventing and mitigating the risks of GBV is a shared one amongst all humanitarian actors. ‘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’.

46 Key Messages and Guidelines for Immediate Action, Gender-based Violence Areas of Responsibility Working Group
48 Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience, and Aiding Recovery, 2015, IASC. See also Humanitarian Charter and Minimum Standards in Humanitarian Response, 2015, Sphere Project: ‘All actors in disaster response must be aware of the risk of […] gender-based violence and must work to prevent and respond to it.’
Overall protection mainstreaming recommendations:

- Preventing and mitigating GBV involves promoting gender equality and promoting beliefs and norms that foster respectful, non-violent gender norms,
- Safety, respect, confidentiality and non-discrimination in relation to survivors and those at risk are vital considerations,
- GBV related interventions should be context-specific, and
- Participation and partnership are cornerstones.

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.

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.

| Assessment Analysis and Planning | 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. Therefore 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. However, GBV survivors should not be sought out or targeted as a specific group during assessments. GBV-specific assessments—which include investigating specific GBV incidents, interviewing survivors about their specific experiences, or conducting research on the scope of GBV in the population—should be conducted only in collaboration with GBV specialists and / or GBV-specialized partner or agency.

General recommendation:

Identify key questions to be considered when integrating GBV concerns into assessments. These questions are subdivided into three categories—(i) Programming, (ii) Policies, and (iii) Communications and Information Sharing. The questions can be used as ‘prompts’ when designing assessments. Information generated from the assessments can be used to contribute to project planning and implementation. |
| --- | --- |
| Resource Mobilization | Addressing GBV is considered lifesaving 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.

General recommendation: Promote the integration of elements related to GBV prevention and mitigation (and, for some sectors, response services for survivors) when mobilizing supplies and human and financial resources. |
| Implementation | In the GBV Guidelines recommendations are subdivided into three categories: (i) Programming, (ii) Policies, and (iii) Communications and Information Sharing.

General recommendations for programming:

- Support the involvement of women, girls, and other at-risk groups within the affected population as programme staff and as leaders in governance mechanisms and community decision-making structures.
- Implement programmes that (1) reflect awareness of the particular GBV risks faced by |
women, girls and other at-risk groups, and (2) address their rights and needs related to safety and security.

- Integrate GBV prevention and mitigation (and, for some sectors, response for survivors) into activities.

**General recommendations for policies:**

- Incorporate GBV prevention and mitigation strategies into programme policies, standards and guidelines from the earliest stages of the emergency.
- Support the integration of GBV risk-reduction strategies into national and local development policies and plans and allocate funding for sustainability.
- Support the revision and adoption of national and local laws and policies (including customary laws and policies) that promote and protect the rights of women, girls, and other at-risk groups.

**General recommendations for communications and information sharing:**

- Work with GBV specialists in order to identify safe, confidential and appropriate systems into sector-specific community outreach and awareness-raising activities; and develop information-sharing standards that promote confidentiality and ensure anonymity of survivors. In the early stages of an emergency, service may be quite limited; referral pathways should be adjusted as services expand.
- Conduct trainings on issues of gender, GBV, women's/human rights, social exclusion, sexuality and psychological first aid for non-specialized GBV organizations.

**Coordination**

Highlights key GBV-related areas of coordination with various sectors.

General recommendation: Sector coordinators and sector actors should identify and work with the chair (and co-chair) of the GBV coordination mechanism.

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, on how to respectfully and supportively engage with survivors.

Efforts to integrate GBV risk-reduction strategies into different sectoral responses should be led by sector actors to ensure that any recommendations from GBV actors are relevant and feasible within the sectoral response.

**Monitoring and Evaluation**

Defines indicators for monitoring and evaluating GBV-related actions through a participatory approach.

General recommendation: For a number of ethical and practical reasons this SOPs do not recommend to use the number of reported cases as an indicator of success. As general rule, GBV specialists should undertake data collection of cases of GBV.

It is the responsibility of all humanitarian actors to ensure safety, confidentiality and informed consent when collecting or sharing GBV-related data.
BOX 5: Integrating GBV prevention and mitigation into humanitarian action

These SOPs refer to the 2015 *IASC Guidelines for Integrating Gender-based Violence Interventions into Humanitarian Action* that set out the rationale for, and obligations of, all sectors to work together to integrate GBV prevention and mitigation into humanitarian action. Links to sector-specific guidelines on how to integrate GBV prevention and mitigation are provided here.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Link</th>
</tr>
</thead>
</table>

7.3 SECURITY AND LEGAL SECTOR⁴⁹

- Maintain adequate security presence;
- Through formal and informal networks, maintain awareness of protection and security issues related to GBV;
- Provide information to the GBV Sub-Cluster and working group about protection and security issues;
- Develop and strengthen specific prevention strategies to address evolving security issues.
- For legal justice actors, raise awareness among the IDP and refugee population on national laws and available legal aid services

7.4 COMMUNITY LEADERS INCLUDING RELIGIOUS LEADERS

• Maintain awareness of GBV risks and issues in the setting, communicate those to security actors and the GBV working group;
• Engage in problem-solving discussions to continuously strengthen prevention strategies
• Actively promote respect for human rights and women’s rights, including equal participation of women
• Ensure peace among and between the communities
• Facilitate reconciliation within their jurisdictions as a means of peace building and conflict mitigation
• Create awareness on GBV prevention

7.5 SOCIAL SERVICE AND CIVIL SOCIETY ORGANIZATIONS

• Provide GBV prevention, protection, care and management services
• Advocate and lobby for enforcement and implementation of GBV related laws, policies and programs.
• Raise awareness on GBV prevention, protection and response.
• Identify and refer at risk individuals to GBV service providers
• Encourage participation and inclusion of marginalized persons
• Ensure non-discrimination, if any action of discrimination is observed report to a service providers
• Influence changes in socio-cultural norms; promote respect for human rights and women rights; ensure survivors have access to information about where to seek assistance and how to report; with consent of the survivor; promote community acceptance and social re-integration of GBV survivors/victims.

7.6 HEALTH/MEDICAL SECTOR

• Implement the Minimum Initial Service Package (MISP) for reproductive health in emergency situations
• Ensure health services are accessible to women and children
• Integrate GBV awareness-raising and behavior change activities into community health activities

CHAPTER 8. INFORMING STAKEHOLDERS ABOUT THE GBV SOPS

The standard operating procedure are most useful when the community can access services and benefit from the agreed upon procedures and practices. This SOP will only be disseminated in paper copy to those relevant organizations that provide services to survivors of gender based violence, members of the GBV Working Group, medical service providers and GBV focal points for clusters. All organizations involved in the referral pathway must provide their staff training on the implementation of the SOP, guiding principles and referral pathway.

8.1 INFORMATION DISSEMINATION TO THE COMMUNITY

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

**Information materials include:**
- Referral pathway leaflets
- Posters;
- Radio information
- Hotline;
- Awareness-raising activities.

**Referral systems should be pasted at strategic points such as:**
- Registration centers;
- Health centres
- Community centers;
- Women’s centers.
- Schools
- Leaflets can be distributed through mobile teams

### 8.2 INFORMATION DISSEMINATION TO OTHER ORGANIZATIONS AND THE GOVERNMENT

- Presentations to senior management of participating organizations and formal endorsement and signature by Heads of Offices
- One-day training to introduce SOPs and Referral Pathways to providers/focal points included in the referral pathway;
- Internal meetings within NGO and UN agencies
- Focal points will present SOPs to colleagues within their organization;
- Case management and Guidelines for Child Protection Trainings

## CHAPTER 9. DOCUMENTATION, DATA AND MONITORING

### 9.1 MAINTAINING CASE FILES

Documentation is an important part of any case management practice. It helps you keep track of what you and the survivor discussed, of what you and the survivor have determined is needed to help her/him, and what steps are being taken to help address the survivor’s needs. Whether you should maintain case files depends on the specific context and the ability to ensure safe, confidential storage of all information. All program data containing information about survivors should be collected and stored in adherence to international standards that prioritize survivors’ confidentiality, safety and security.

If you determine that it is safe to put a system in place for collecting survivor data, you should develop and use a consent form and basic assessment tool. Other forms that can be part of case documentation include a case action plan, a written safety plan, case notes, a referral form, a case follow-up form and a case closure form.

- Each survivor should have a separate case file that includes all relevant completed case management forms.
- A code should be assigned to and marked on the front of each case file.
- **Names should never be recorded on the front of case files and photos should never be affixed to case files.**
- To protect confidentiality, a list linking the case file codes to the survivors’ names should be stored in a different location, or stored electronically through a password protected file.
Information collected about survivors belongs to them, and they should have access to review and read the information at any time as part of their meaningful participation.

9.2 GBVIMS

The GBVIMS is a robust system for collecting, storing and sharing key information on GBV incidents. It was created to harmonize data collection on GBV in humanitarian settings, to provide a simple system for GBV project managers to collect, store and analyze their data, and to enable the safe and ethical sharing of reported GBV incident data. The GBVIMS 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.

Sharing non-identifying data: The GBVIMS was piloted early 2015 and the Information Sharing Protocol is currently signed by 18 data gathering organization covering 11 governorates, UNFPA and UNHCR. The GBVIMS was developed in partnership with data collecting agencies to guide the safe, confidential and ethical collection, analysis and utilization of GBVIMS data (non-identifying statistical data). GBVIMS data is compiled from each GBVIMS signatory into a monthly reports and shared amongst signatories and pre-approved external actors. Any organization wishing to access data generated from the GBVIMS or contribute data to the GBVIMS may make a formal request for to UNFPA as lead coordinating agency.

All GBV case management agencies part of the GBVIMS are responsible for documenting GBV cases. For actors not part of the GBVIMS, this SOP includes intake, referral and consent forms that can be used by the lead agencies when a GBV case is reported.

Medical Intake and Assessment forms are only to be used by specialized agencies. Agency staff charged with collecting the initial intake information from the survivor were appropriately trained on how to fill out the forms and how to act in accordance with the guiding principles.

9.3 DATA SECURITY

Most GBV actors both using and not using the GBVIMS use intake forms. Intake forms contain extremely confidential and sensitive information and this information may only be shared with others under certain circumstances (refer to Chapter 4.4 Informed Consent and Information Sharing and section below).

If you are maintaining paper copies of case information:

- Only print information if it is absolutely necessary. Where possible, promote a paper-free working environment to reduce the amount of information that is printed. In most cases, however, caseworkers will not have access to computers or hand-held data devices and will thus use paper forms to document cases. If information is printed, register each copy by applying serial numbers (or coding) and track them on a spreadsheet. Ensure that only those authorized to access these documents in your organization are aware that they are accountable for the security of them.
- In line with your organization’s data protection and archiving policies, destroy all printed material that is no longer needed. You can do this by shredding or burning (if safe to do so).
- Store printed material in a locked file cabinet or other secure container, and limit access to the combination or keys. Rooms containing paper and electronic information must be locked securely when staff leaves the room. All staff should be aware of the importance of being vigilant as to who is entering the room where they work and for what purpose.
- Have a plan in place for destroying all information in the case of an emergency or evacuation.

If you are maintaining electronic case information:

- Do not email information unless absolutely necessary. When you do send an email, include instructions for the recipients so that they are aware the information in the email and its attached files is sensitive. This could include caveats such as “Limited Distribution: Do not disseminate this email or attachments without permission from…”
- Store electronic data on a single computer or removable storage device, such as a flash drive, and keep limited backup copies.
• Secure backup copies in a locked, safe or room, or keep flash drives with you at all times.
• Access to information should be controlled. This includes establishing protocols for all staff accessing or using survivor information, and limiting access to computers used to store confidential data.
• Information stored electronically should be password protected. Use a series of passwords, establishing a different one for each level of information. Maintain security by ensuring that each user knows only the passwords to the information for which she/he has legitimate need.
• Use identifiers to mask personal identities. Develop a system of codes to assign unique identifiers to each survivor, using numbers, letters from their last name or other codes. Only the person who first assigns the identifier and enters the information into the computer should know the identity of the client.

Completed intake forms should never be transferred or shared between agencies to maintain the safety, security and confidentiality of information. As per GBVIMS guidelines, only in rare situations it may be necessary to share all or part of a case file:
• If total care/support of a survivor is being transferred because an organization is pulling out or the survivor is moving to a new location where another organization will provide support (with survivor consent);
• Donors or other external entities should not mandate that service providers submit individual case files (i.e. intake or incident report form) as routine reporting.
• DO NOT share case files without the consent of the survivor and only on extraordinary occasions according to the needs of the survivor with explicit consent.

It is recommended that all case files should be kept for a period of 5 years, after which they can be destroyed. Any further reference on the case can be retrieved from electronic archives. However, each organization should have its own internal protocols for how long to keep case files until it should be destroyed after a case is closed and when the survivor declines transfer to another organization. In some cases (e.g., refugees), case information is needed for resettlement purposes, in which case electronic case information can be used. Closed case files should not be transferred without survivor consent.

9.4 DATA SHARING BEST PRACTICES

It is important to remember that GBV is happening everywhere. It is under-reported, due to fears of stigma or retaliation, limited availability or accessibility of trusted service providers, impunity for perpetrators, and lack of awareness of the benefits of seeking care. Waiting for or seeking population-based data on the true magnitude of GBV should not be a priority in an emergency due to safety and ethical challenges in collecting such data. With this in mind, all humanitarian personnel ought to assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take actions based on these SOPs, regardless of the presence or absence of concrete ‘evidence’\(^{50}\).

When examining GBV in humanitarian crises, the discussion often turns toward how many cases there have been. Though “getting the numbers” may, at first glance, seem like the most logical and efficient way to understand any issue, placing too much emphasis on counting GBV cases can – for a number of reasons – actually be counterproductive. Focusing only on numbers not only fail to capture the true extent and scale of the GBV that is occurring, it can also expose survivors to further harm, lead to misinterpretations of the data, and result in other, more useful sources of information being dismissed or ignored. Therefore, it is not recommended that the number of cases cared for by a service provider is shared or publicized. Other types of data – both quantitative and qualitative – on GBV patterns, trends and risks can help paint a fuller picture, particularly when multiple sources are reviewed and analyzed together. Pressuring service providers for case data compromises their ability to provide life-saving care. Therefore, in Iraq response, less emphasis should be placed on counting cases.

\(^{50}\) Inter-Agency Standing Committee. 2015. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery.
CHAPTER 10. COORDINATION MECHANISMS

Effective prevention and response to child protection and gender based violence require multi-sectoral coordinated action among, at a minimum, health and social service actors, legal, human rights, and security sectors and the community.

- Effective prevention and response to GBV require multi-sectoral coordinated action among, at a minimum, health and social services actors, legal, human rights, and security sectors and the community. Gender-Based Violence sub-cluster/working groups are the coordinating body with the objective to strengthen GBV prevention and response in emergency settings, with a focus on internally displaced persons, refugees in the camps and in the host communities including host population at risk of gender based violence.
- GBV prevention and response is coordinated by GBV sub-cluster at the nation level and GBV working group at governorate level (Annex 5). Members of the Working Group are drawn from UN Agencies, INGOs, LNOGs, Civil Society and key ministries.
- GBV Working Group meetings are held before the national Sub-Cluster meetings to allow issues raised at governorate level to be discussed at a higher level for guidance and support.
- The GBV Working Groups work closely with camp level structures/committees to understand protection issues and provide support when needed.
- The GBV Working groups work closely with clusters. There are Focal Points designated to attend cluster meetings and feed back to the GBV working group meetings to support GBV mainstreaming in cluster programs and activities.
All participating agencies and refugee groups mentioned in the document demonstrate, with a signature, their commitment to the SOPs

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>DATE</th>
<th>SIGNATURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 4:

Capacity to consent and best interest flow-chart

1. Assume capacity

2. Provide information in a way that you think the survivor will understand.

3. Give time for them to think about the information and to ask questions.

4. If they can’t speak, look for other methods, such as gestures to indicate that they agree or disagree (yes or no).

11. What is in the best interests of the survivor?
   - Document how you came to this decision, including who you consulted with in the making the decision.
   - Document the potential negative and positive outcomes of the action on the survivor’s physical, emotional and social well-being.

12. Is this the least harmful course of action?
   - YES
   - NO

13. Explain the decision to the survivor in a way that you think they will understand.

14. Give time for them to think about the information and to ask questions.

15. If they can’t speak, look for other methods, such as gestures to indicate that they agree or disagree (yes or no).

5. Do they remember the information? Can they repeat it back to you in their own way?
   - NO
   - YES

6. Do they understand that there are options? Can they describe these options to you?
   - NO
   - YES

7. Do they understand the risks and benefits of each option?
   - e.g. What do you think might happen if you go to the health center? How could it be helpful for you? What are the good things about this option? How could it be harmful to you? What are the bad things about this option?
   - NO
   - YES

8. Do they understand the likely effects of not having services?
   - e.g. What might happen if you decide not to go to the health center?
   - NO
   - YES

9. Is the person being coerced?
   - Are they just agreeing with everything you say? Are family members and caregivers telling them what to say?
   - NO
   - YES

10. Can the survivor explain the reason for their decision?
   - e.g. What do you want to do? Why do you want to do this?
   - NO
   - YES

Repet steps 2-4 again. Be prepared to do this several times. If they still don’t understand go to 11.

The survivor may not be able to consent
- Document how you came to this decision. Which steps were not achieved?

Seek advice from your supervisor.

NO

16. Is the action aligned with the wishes of the survivor?
   - YES
   - NO

Carry out actions in the survivor’s best interest.

NO

Yes
Annex 5:

GBV Sub-Cluster - Iraq
Coordination Structure
August 2017

GBV Sub-Cluster
Chair: UNFPA (Nicia Danniawi)
Co-Chair: Information Management: UNFPA (Alisher Ashurov)

Basrah GBV Working Group
Chair: UNHCR (Doaa Elbayad)

Center-South (Baghdad) GBV Working Group
Chair: UNFPA (Eni Temgouche)
Co-Chair: MoLSA
Co-Chair: IMC (Hamid Oyombe)

Diyala GBV Focal Point
UNFPA (Mohammed Alwan)

Dahuk/Northern Nineva GBV Working Group
Chair: DCVAW (Reed Aram Afroushi)
Co-Chair: UNFPA (Gertrude Mubrun)
Co-Chair: UNHCR (Kani Areef)

Erbil GBV Working Group
Chair: UNFPA (Ali Zedan)
Co-Chair: NRC (Lara Fakhoury)

Kirkuk GBV Working Group
Chair: NRC (Shantia Abdulaziz)
Co-Chair: Islamic Relief (Mohammed Medhat)

Sulaymaniyah GBV Working Group
Chair: UNFPA (Omer Habib)
Co-Chair: UNHCR (Rehab Khalefa)