THE REGIONAL SAFE SPACES NETWORK IN THE AMERICAS

LESSONS LEARNED AND TOOLKIT

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REGIONAL SAFE SPACES NETWORK


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The Regional Safe Spaces Network (hereinafter RSSN or "the Network") was established in the Americas region in 2017 with the support of the UNHCR's Regional Legal Unit of the Americas Bureau (RLU), and particularly its Sexual and Gender-based Violence (SGBV) and Child Protection (CP) team (RLU SGBV/CP). The Network coordinated by the RLU SGBV/CP led the development and implementation of a regional protection strategy to address the needs of people displaced as a result of violence and persecution and other people on the move. In consultation with partners and communities the Network focused on improving access to essential services for women, girls, but also men and boys survivors of SGBV, children at risk, LGBTI[1] people with protection needs, and other people affected by serious human rights violations. The Network developed this Toolkit, promoting common standards to foster cross-border coordination in the North of Central America and the countries affected by the Venezuelan situation[2]. It includes tools developed or used by the network. The toolkit is a living document that will be reviewed and updated as the Network expands and develops new tools. At present, more than 50 organizations providing services in seven different countries[3] are members of the Network and it is expected that new members and countries will join it in the coming months. The RSSN members and its coordinator like to thank all those who participated in the development of toolkit, and particularly the RLU SGBV/CP team members, and the SGBV unit of the UNHCR's Division of International Protection (DIP) for its continued support and assistance throughout the design and implementation process, as well as the Sexual Violence Program of the Human Rights Center, Berkeley School of Law for its valuable contribution.

1. Lesbian, Gay, Bisexual and Transgender and Intersex.
2. Asylum seekers from Venezuela 2014-2018 https://data2.unhcr.org/en/situations/vensit
3. Costa Rica, Guatemala, Mexico, Colombia, Venezuela, Chile, and Peru.

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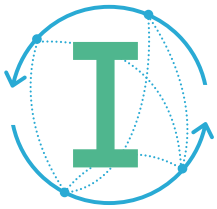
PART 1:
INTRODUCTION



REGIONAL SAFE SPACES NETWORK (RSSN) LESSONS LEARNED
JUNE 2018

AMERICAS REGION

In recent years[4], the region has witnessed a dramatic increase in the number of asylum-seekers particularly from the **North of Central America (hereinafter "NCA")** and **Venezuela** moving in all directions across borders.

RSSN

The Network includes more than 50 members: UNHCR, UNFPA, IOM, national institutions, civil society, faith-based organizations, and community volunteers working on **SGBV, child protection and human rights** in NCA, Venezuela and neighboring countries.

AGE, GENDER, DIVERSITY (AGD)[5] & SURVIVOR-CENTERED APPROACH[6], CHILD'S BEST INTERESTS PRINCIPLE[7]:

The RSSN aims to **improve disclosure**[8] of serious protection incidents, reaching out to the most **vulnerable individuals** and ensuring **delivery of quality services** along the displacement cycle[9].

PROJECT OVERVIEW

In 2016, the Child Protection & SGBV team of the Regional Legal Unit (RLU) in the Americas developed the Regional Safe Spaces Network (RSSN) strategy to improve access to services for survivors of sexual and gender-based violence (SGBV), children at risk, people with diverse sexual orientation and gender identity, people with disabilities, indigenous population and other vulnerable individuals at every phase of the displacement cycle throughout the Americas.

4. Refer to 2018 data *https://data2.unhcr.org/en/situations/vensit*
5. Refer to UNHCR Policy on Age, Gender and Diversity, 8 March 2018. Available at: *http://www.unhcr.org/protection/women/5aa13c0c7/policy-age-gender-diversity-accountability-2018.html*
6. Respecting the interest and wishes of the survivor, child or other person of concern; ensuring their right to confidentiality while prioritizing their safety; providing services and support without any discrimination on any grounds
7. UNHCR Guidelines on Determining the Best Interests of the Child (2008) *http://www.unhcr.org/4566b16b2.pdf*
8. Disclosure is when an individual approaches a case manager or service provider and tells them what happened with him/her. He or she may disclose his/her experience to a trusted family member or friend.
9. The "displacement cycle" refers to four phases of displacement (origin, transit, destination, return).

The RSSN was established in 2017. The Network prioritized the North of Central America (NCA), Venezuela and neighboring countries to address the needs of displaced populations fleeing violence and persecution. At present the RSSN has more than 50 members including UN and non-UN agencies, civil society, faith-based organizations, national institutions and community-volunteer networks working in seven countries in the Americas (Mexico, Guatemala, Costa Rica, Venezuela, Colombia, Peru and Chile). It is expected that the Network will continue to expand to other countries following trends in displacement.

A Safe Space is a kind of physical or mobile[10] space, where groups or individuals can feel "safe," build social networks, express and entertain themselves while receiving information and accessing protection and assistance services in accordance with the age, gender and diversity approach, the survivor-centered approach, and the child's best interests principle.

The personnel in Safe Spaces are aware of SGBV, child protection, and humanitarian principles. They must treat survivors of SGBV, children and vulnerable people in a non-discriminatory manner, with respect and compassion in order to facilitate disclosure of SGBV incidents and other violations of human rights.

Members of the **Network coordinate their responses in order to provide safe and confidential case management and referrals to specialized services.** They also conduct community outreach or awareness-raising activities in a harmonized and coordinated manner with refugees, asylum-seekers, internally displaced people (IDPs), returnees, people on the move, stateless and other persons who may need international protection.

ESSENTIAL PACKAGE OF SERVICES

- **SGBV/Child Protection case management for adults and children, including best interest procedures;**
- **Mental health and psychosocial support (MHPSS);**
- **Medical or health services, in particular sexual and reproductive health services and Clinical Management of Rape (CMR);**
- **Legal assistance to access justice and other legal procedures;**
- **Safety: in shelters or through community-based solutions;**
- **Family tracing and reunification;**
- **Alternative care arrangements.**

10. Such mobile services could offer to meet women and girls, or men and boys where they are, rather than requiring them to travel to a fixed location. Mobile health clinics, outreach and group counselling in remote areas are good examples of such as services. In the NCA, UNHCR and partners coordinate with the education and community centers in gang-controlled areas to support protection delivery.

OBJECTIVES OF THE NETWORK

The RSSN in the Americas draws on experiences from the work of existing networks in the region, prioritizing cooperation with different actors and community members. The Network focuses on three main objectives:

a. **Outreach with vulnerable people:** The RSSN provides information to women and girls, and men and boys of diverse background and facilitates disclosure of SGBV and other serious violations of human rights to ensure access to protection services along the displacement cycle. The Network also promotes the empowerment of survivors and people at risk, while respecting the principle of confidentiality and the wishes of the affected individuals.

b. **Case Management (CM) & Multi-sectoral services (Essential Package) across borders:** UN agencies, civil society organizations, faith-based organizations, government institutions, and community-volunteer networks work together to facilitate access and harmonize services across countries for SGBV survivors, children at risk, and other vulnerable persons. The Network ensures a continuum of protection during ongoing cycles of displacement.

c. **Information Management (IM):** The safety and security of people of concern and service providers are priorities of the RSSN. When managing personal information, e.g. via service mapping, data collection and dissemination, the highest protection standards for security and protection must be standardized across different service delivery methods and programme planning phases.

ACTIVITES

MAPPING OF SAFE SPACES' SERVICES AND REFERRAL[11] PATHWAYS

A focused mapping of Safe Spaces related services adhering to basic humanitarian principles[12] commenced with Mexico, Guatemala, Costa Rica, Colombia and Venezuela. Working with a diverse range of partners in these countries, they identified gaps in service provision and strengthened coordination around referral pathways for different profiles of persons of concern.

11. Referrals means linking survivors, children or other persons of concern to other services, providing information about the case to a different partner or unit and on a need-to-know basis. For more information, refer to workshop PowerPoint and handouts available in the RSSN Toolkit.
12. Based on principles of humanity, impartiality, neutrality and independence found in the International humanitarian law, taken up by the United Nations in General Assembly Resolutions 46/182 and 58/114.

From this alliance, both a physical and an online map showing the geographical location of each service as well as which organizations offer multiple services among the five countries were developed in order to facilitate referrals in the surrounding geographical area and particularly along the transit routes across countries.

CROSS-BORDER COORDINATION

The RSSN ensures coordination between safe spaces at local and national levels. Its core members worked in close consultation with all other members that are spread across different locations to develop standards, tools, and policies. The resulting Terms of Reference (ToR) establishes the main objectives and interventions of the Network and outlines the roles of the different members. Additionally, a regional plan of action guides the implementation towards contextualized work plans. Tools for advocacy, capacity building, and information management were also developed jointly to increase the quality and impact of services.

SETTING MINIMUM STANDARDS: THE RSSN SELF-AUDIT CHECK-LIST

The Network developed a set of minimum standards and the RSSN self-audit checklist to measure their implementation. The standards relate to service provision approaches, human resources, information and case management, and accountability to the population served. The checklist helps track changes in local, national and the RSSN over time. The members of the RSSN engaged in a joint audit and compiled the outcomes of individual organizations into a regional self-evaluation. The progress and gaps identified were used to develop a work plan targeting capacity development, awareness raising, case and information management.

DEVELOPMENT OF PROTECTION TOOLS, GUIDANCE AND TRAINING MATERIALS

The SGBV and Child Protection Case Management and Information Management (hereinafter "SGBV/CP CM/IM") Toolkit assembles several tools in one place for use by UNHCR and its partners. The toolkit includes the SGBV/CP case management and information management workshop tools, the RSSN self-audit checklist, an online service mapping, a research on SGBV disclosure in forced displacement, and a Regional Information Sharing Protocol (RISP) template. This toolkit will be further developed and updated as the Network expands its work.

CAPACITY BUILDING

The RSSN is supported by the UNHCR's RLU SGBV/CP team in San Jose, Costa Rica. The team provides capacity building, technical support and guidance on global and regional protection standards and RSSN tools to the members of the Network. In total, 474 staff of RSSN member organizations were trained on SGBV/CP principles and RSSN tools in the Americas Region from July 2017 to July 2018.

RSSN MEMBERS

UNHCR operations in Mexico, Guatemala, Costa Rica, Colombia, Venezuela, Peru and Chile have established the Regional Safe Spaces Network in coordination with implementing and operational partners to provide specialized services to SGBV survivors, children at risk and other vulnerable individuals of diverse backgrounds. The RSSN comprises civil society organizations, community volunteer networks, faith-based organizations, government institutions and UN agencies as members or allies to the RSSN to ensure linking survivors, children at risk, and vulnerable people to life-saving services. To date more than 50 organizations are members by the RSSN.

LESSONS LEARNED

- **USING A PHASED APPROACH:**
  At the beginning it was more effective to concentrate the use of precious human and financial resources on the capacity and quality of a few services, rather than trying to involve all the actors and services available in a particular geographic zone. This allows for a quicker roll out of the project, evaluation, and planning for next phases.

- **CROSS-BORDER COORDINATION:**
  Depending on the wishes of survivors, children at risk, and other vulnerable people, services should be made readily available across borders in accordance with agreed standards. Coordinated RSSN discussions around multi-country case management and referral pathways should consider the availability and quality of services within and across borders when applicable.

- **AVAILABILITY OF AN ESSENTIAL PACKAGE OF SERVICES TO SURVIVORS, CHILDREN AT RISK, AND OTHER VULNERABLE PEOPLE:**
  In order to provide survivors, children at risk, and other vulnerable populations with information as part of the SGBV/Child Protection Case Management (hereinafter "SGBV/CP CM") process, capacity building for case managers should include compiled information on available services along common transit routes across countries. When a necessary service is not along the transit route, the case manager should be prepared with information on a location providing that service. To provide the same standards to all people in need, members of the network are trained on the implementation of the agreed standards and tools, which are in line with UNHCR and IASC protection principles.

- **COMPLAINT AND FEEDBACK MECHANISMS:**
  Forced displacement exposes refugees and people on the move to serious protection and exploitation related risks. Agencies and service providers in the NCA, Venezuela and neighboring countries have identified that the heightened risk of sexual exploitation and abuse for women, girls, boys and LGBTI people are due to increasing vulnerabilities, and the limitations in accessing services and assistance. Safe spaces providing services in border areas and along the displacement cycle should exercise particular caution to ensure the accessibility of complaint and feedback mechanisms for all individuals in accordance with the AGD approach.

- **SGBV/CHILD PROTECTION CASE MANAGEMENT (SGBV/CP CM) VS. SERVICE PROVISION:** Continue to emphasize SGBV/CP CM as distinct from specific service provisions. SGBV/CP CM is a collaborative and structured method for providing help to survivors of SGBV, children at risk and vulnerable people from diverse backgrounds. It involves an organization taking the responsibility to ensure that the affected individuals are informed of all options available to them and that protection risks and issues are identified and followed up in a coordinated manner by relevant actors and service providers. Effective CM and service provision will involve the development and implementation of inter-agency SOPs and referral pathways[13].

- **SGBV/CP INFORMATION MANAGEMENT (SGBV/CP IM):**
  Continue to emphasize SGBV/CP CM as a distinct process from SGBV/CP IM although the two are interrelated. SGBV/CP CM involves actual protection delivery and service provision while IM is the process of documenting the information and interventions related to the case to track progress and facilitate follow up between UNHCR, partners, civil society organizations, faith-based organizations, government institutions and communities. Effective CM and IM will involve the development of inter-agency referrals and information sharing protocols as well as capacity building interventions.

- **SGBV/CP CM & IM CAPACITY BUILDING:**
  These related concepts and tools outlined below need to be included in any capacity building dedicated to SGBV/CP CM and IM (including proGres v4 SGBV[14] and CP modules):
  - Age, gender and diversity approach;
  - Survivor-Centred approach;
  - The Child's Best Interests Principle;
  - Informed Consent of the survivor/other person of concern; informed assent for children;
  - Confidentiality of information;
  - Data Protection Measures;
  - SGBV/CP IM tools;
  - RSSN Toolkit;
  - Inter-Agency coordination.

13. Adapted from the Interagency Gender-based Violence Case Management Guidelines 2017
14. The 6 core types in the SGBV module in ProGres V4 coincide with the classification of incidents established in the GBVIMS.

- **SELF-CARE:**
  Be sure to emphasize the importance of consistently implementing self-care in interventions offering strategies and tools to staff through capacity building and learning events.

- **USER ACCESS RIGHTS TO PROGRES V4 SGBV AND CP MODULES:**
  These are granted after approval from the ranking Protection Officer in an operation in accordance with the Standard Operating Procedures (SOPs). Only the SGBV/CP case worker opening the case and their supervisor/case manager will be able to view the protection case record. System restrictions for SGBV and CP module must be considered when granting user access rights.

- **LANGUAGE OF TRAINING:**
  If resources allow, simultaneous interpretation of any training event is important in the Americas to ensure full participation of RSSN members coming from different sub-regions (English, Spanish, and Portuguese). Some training sessions may need to include English phrases and translations to better correlate the training session with the tools to be used in practice. For example, although proGres v4 is being translated, UNHCR and RSSN members currently using the system will require information in English to effectively navigate and utilize the existing proGres modules until the Spanish translation is complete. During face-to-face sessions simultaneous interpretation is offered to facilitate discussions. Translations of training modules are also prioritized.

POTENTIAL RISKS and MITIGATION STRATEGIES

In the context of forced displacement reaching most vulnerable people is extremely challenging, particularly when working with fast moving populations. Building trust, facilitating disclosure and offering services in a safe and ethical manner is sometimes hindered by the presence of armed groups, gangs and traffickers. Limited resources and capacity of individual service providers exacerbate these risks. Some risk mitigations strategies include:

- A research on SGBV disclosure in forced displacement conducted in Mexico and Guatemala with the support of the Human Rights Center of the University of Berkeley. The research includes a reflection on types of disclosure and strategies to ensure access to support by survivors, children at risk, and other persons of concern as well as several sample tools to help implement them. The full text of the research it is included in the RSSN toolkit.

- The various types of standards applied across multiple actors tends to complicate the guarantee of equal access for individuals in need of protection. The RSSN self-audit checklist developed and agreed by members of the Network helps first responders to measure their progress in the implementation of Safe Spaces for all refugees and other displaced population.
- Data protection measures are put in place and regularly reviewed to protect survivors, children at risk, and other vulnerable population, their families and communities, as well as service providers. Examples include the use of codes in place of the names of survivors, children, or other persons of concern and installation of locking file cabinets to store separately any details regarding a case from any identifying information that could be linked to a survivor of serious human rights violations such as SGBV.
- The RSSN will continue to promote the most efficient referrals to services available to any survivors, children at risk, and vulnerable people across countries, but also ensuring that an array of options for other service providers exist nearby in order to reduce the risk of stigma that may be associated with being linked to any one specific service provider.
- The RSSN will continue to support the establishment of enhanced complaint and feedback mechanisms in order to prevent the risk of and to respond to possible incidents of Sexual Exploitation and Abuse (SEA) and other forms of exploitation, abuse and misconduct perpetrated by service providers. Feedback mechanisms will also be an essential part of any community-based protection strategy to ensure relevance and quality of the programme implemented through the active engagement of the community.
- Members of the Network can independently determine whether they would like to be included in any public visibility materials on the RSSN such as a public mapping of service locations.
- Communities and national institutions are engaged from the beginning to ensure required contextualization and the implementation of effective risk mitigation strategies.
- Maintaining an internal online and offline map that is available to only RSSN members will widen the network of available services that can be shared while simultaneously allowing discretion on the visibility of specific services (i.e. safe shelters, LGBTI-friendly services, etc.)
- The implementation of a Regional Information Sharing Protocol (RISP) will facilitate inter-agency and multi-country case management as well as joint evidence-based programme planning.

II REGIONAL SAFE SPACES NETWORK: SUSTAINABILITY AND RECOMMENDATIONS

SUSTAINABILITY PLAN

CATEGORY	SUSTAINABILITY ELEMENTS
PARTNERSHIPS	• A phased approach to the project is used to coordinate protection delivery with civil society organizations, faith-based organizations, government institutions, UN agencies and communities. • Partners that are likely to continue providing SGBV/CP case management services are consulted regarding their capacity related to information management and their interest in engaging in Network activities with their current staff. • The RSSN focuses on current members with capacity and will slowly expand to include other interested actors and institutions depending on geographic area and service coverage.
ORGANIZATIONAL CAPACITY	• National level focal points for the RSSN receive continued technical support from the RLU in the form of RSSN presentation, training materials, regional training opportunities and missions based on available regional level funding.
EVALUATION	• Through mixed methods of evaluation, various elements of the project will be considered, including self-evaluation of Safe Spaces conducted by members, capacity-building assessments, safety audits and review of key indicators.
ADAPTATION	• Allow for varied levels of engagement within the Network, recognizing that not all members and institutions will be able to move forward at the same time with different speeds. • Even though many training materials and SGBV/CP CM/IM tools are standardized, flexibility is built into the Network with adapted and contextualized training events.

MANAGERIAL AND INSTITUTIONAL SUPPORT	• The RLU SGBV/CP in the Americas Bureau takes the lead to provide regular updates and ensure support for the RSSN as a regional best practice. • The initiative counts with the support of the UNHCR's Division of International Protection (DIP), the Americas Bureau Director and other Senior Managers. • The RSSN was developed in the context of the implementation of the Brazil Declaration and Plan of Action 2014[15], and the New York Declaration 2016[16]. • The RSSN is a strategy embedded in the Comprehensive Refugee Response Framework (MIRPS[17] in Spanish) • UNHCR country operations that are members of the RSSN leverage their relationships with government counterparts to organize capacity building opportunities for personnel in key institutions.
FUNDING STABILITY	• The RSSN uses existing country and regional budgets. • The RSSN counts with additional support from the DIP and the Americas Bureau. • UNHCR operations work with members at national level within the range of their planned programs to negotiate the best use of available funds for the greatest impact on persons of concern.
COMMUNICATIONS	• Coordination around communication within the RSSN is centralized at the regional level by the Coordinators of the RSSN located in the RLU that guide the types of documents produced. • Webinars, emails and briefing notes on the RSSN are produced at regional level and shared with the RSSN focal points in UNHCR at national and field levels for further distribution of information to partners and government officials.
STRATEGIC PLANNING	• The multi-year planning cycle of the RSSN has a 3-year span. • Annual reviews of activities to date allow for a re-alignment of resources at the start of each budget cycle.

15. Brazil Declaration and Plan of Action *http://www.acnur.org/cartagena30/en/brazil-declaration-and-plan-of-action/*
16. New York Declaration for Refugees and Migrants *http://www.unhcr.org/new-york-declaration-for-refugees-and-migrants.html*
17. Marco Integral para la Protección y Soluciones *http://www.acnur.org/marco-integral-regional-para-la-proteccion-y-soluciones-mirps.html*

RECOMMENDATIONS

- A flexible approach to protection (SGBV/CP) case management adapted for the Americas Region is required to address the challenges in quality service provision presented by a quickly moving population of concern. This includes improving coordination around cross-border referrals and transfers[18] of cases to ensure a continuum of protection along the displacement cycle, by increasing access to the Essential Package of services for SGBV survivors, children at risk and other vulnerable people.
- Due to high staff turnover in the region and limited resources in the RSSN, the Network should designate a focal point and back up person that oversees capacity building opportunities to ensure the sustainability of the RSSN.
- In order to maximize accessibility, dissemination, and promotion of the RSSN standards and tools, the RSSN Toolkit should be developed in both English and Spanish.
- RSSN members should reach out to operations interested in joining the RSSN by promoting the use of the SGBV and CP Information Management (CP/SGBV IM) Toolkit that includes forms, checklists, and protocols to help operations align with regional and global SGBV and CP IM standards.
- Include both Spanish and English terminology in SGBV Incident Classification and Specific Needs Codes training sessions in the Americas to correspond with terms found in proGres v4 (currently in English with Spanish translation efforts underway). Portuguese materials should also be developed.
- Note that not all actors and members will be in a position to move forward at the same time in each phase of the project. Continue to include a balance between UNHCR and member focal points from all operations within the RSSN when planning capacity building opportunities and to allot an appropriate amount of time for regional tools to be adapted for proper use within organizations.
- Ensure that development and implementation of the Regional Information Sharing Protocol (RISP) in the Americas will promote global standards related to SGBV/CP information management for protection delivery and evidence-based program planning.

18. Transferring: handing over the case to another case management agency or a different unit within the same agency; ownership of case is transferred. Refer to Workshop PowerPoint for more information.

PART 2:
REGIONAL SAFE SPACES NETWORK TOOLKIT

REGIONAL SAFE SPACES NETWORK (RSSN) MAPPING

TOOL: REGIONAL SAFE SPACES NETWORK
SERVICE MAPPING: A COLLECTION TOOL (AMERICAS REGION)

This tool is intended for use by UNHCR, SGBV, CP and other protection service providers within the Regional Safe Spaces Network and other agencies providing multi-sectoral services to provide counselling and conduct referrals across borders. It is not intended for the purpose of developing awareness-raising materials and is not to be disseminated in the community without previous adaptation. The tool is to be developed by and shared between organizations in the Network and other relevant agencies providing specialized SGBV, CP and other humanitarian and protection services, to refugees, asylum-seekers, IDPs, returnees, stateless persons, people on the move and others who might be in need of international protection.

MAPPING OF SGBV/CP SERVICES: **Basic questions for RSSN focal points to consider during the mapping exercise.**
1. Which services out of the Essential Package* of services for SGBV survivors, children at risk, or other vulnerable people and other multi-sectoral services are available in your safe space?
2. Do persons of concern with different ages, genders, and backgrounds have access to these services?
3. Are these services safe and accessible with adequate staff and resources?
4. Does the service meet the minimum standards of service provision or does the service require more capacity development?

*The Essential Package includes: 1) SGBV/CP case management services, 2) Mental health and psychosocial support, 3) Medical or health services, 4) Legal assistance, 5) Safety, 6) Family tracing and reunification, 7) Alternative care, and 8) Education.

WHO DOES WHAT WHERE (3WS): Which organizations within the Regional Safe Spaces Network provide services to survivors, children at risk, and other individuals at risk (considering the Essential Package of SGBV/CP services plus other multi-sectoral services)?

INSTRUCTIONS: In the box corresponding to each service, fill in the 1) focal point name; 2) focal point contact phone number; 3) address of service provider if known; and 4) GPS coordinates of the organization providing the specialized service to POC.**

ORGANIZATION		ORG 1 NAME	ORG 2 NAME	ORG 3 NAME	ORG 4 NAME	ORG 5 NAME
Mental Health and psycho-social support						
Legal Assistance						
Sexual and reproductive health (SRH) services						
Clinical Management of Rape (CMR)						
Case Management (CM)						
BIA/BID						
Safety and protection services						
Outreach activities						
Education	Formal					
	Informal					
Other service						

**Please use the GPS coordinates format of 2 numbers separated by a comma (i.e. 9.9420879, -84.1160463). To obtain the GPS coordinates of a service location, see the separate document entitled, "How to Obtain GPS Coordinates in Google Maps" or go directly to the website for Google Maps.

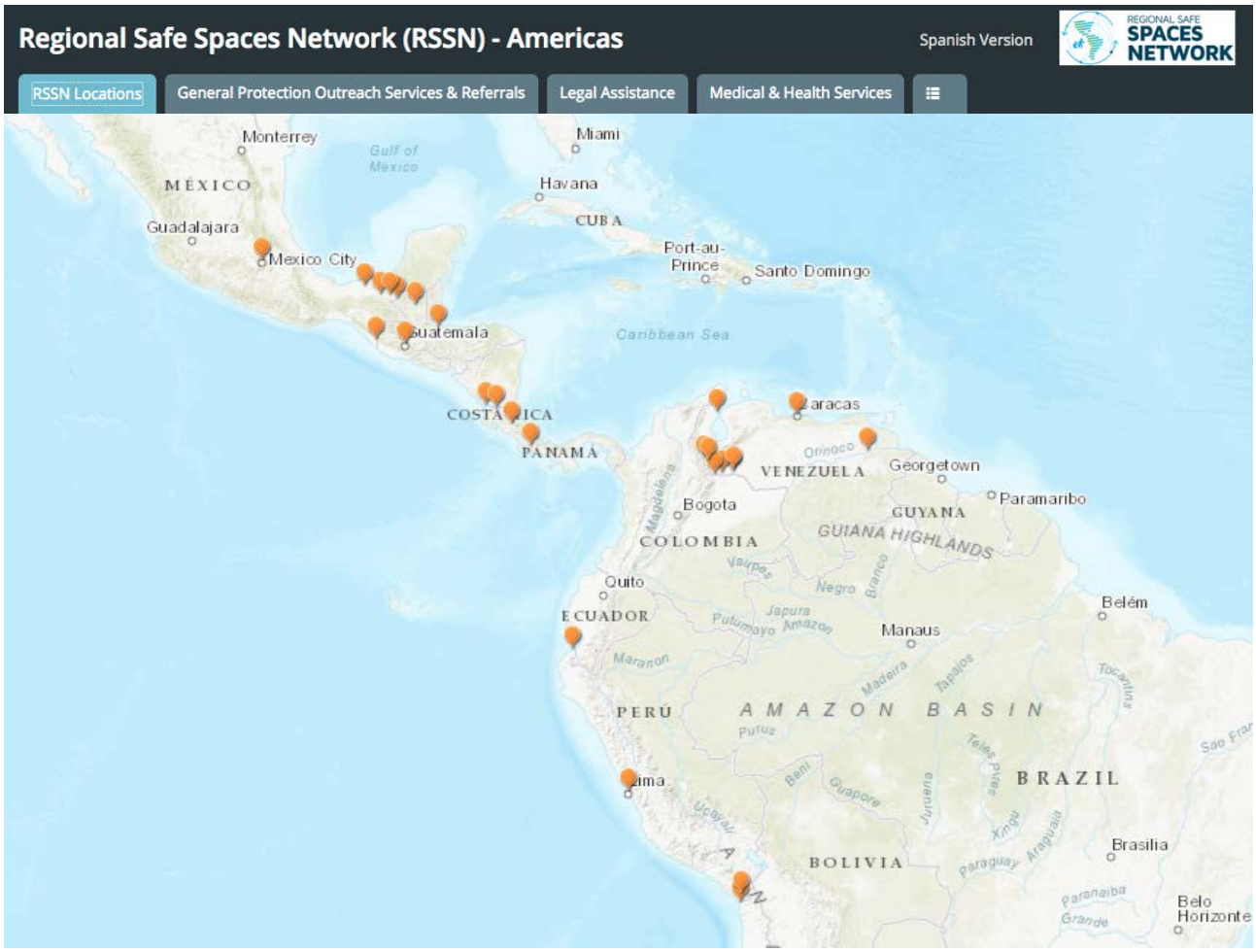
MAP OF SERVICES USED BY REGIONAL SAFE SPACES NETWORK: Organizations, institutions and agencies providing services to survivors, children and individuals with protection needs***

INSTRUCTIONS: Fill in the service provided by each organization or institution in the boxes below the type of case in the column heading. Include a number "1" for the org/institution if they are the focal point. Include a number "2" for the organization or institution if they are the "back-up". *See the example entries in the chart.*

Organization/ Institution	GIRLS	BOYS	WOMEN	MEN	LGBTI	Persons with disabilities	Other specific profile
ORG 1 NAME	1.Psycho-social	Psycho-social					
ORG 2 NAME	1.Legal	Legal		Psycho-social		Psycho-social	
ORG 3 NAME		Informal education	Legal	Legal, health			
ORG 4 NAME	Referral to formal education		Psycho-social		1.Psycho-social, Legal, CM	Recreation	
INSTITUTION 1	2.CM	2.CM					
INSTITUTION 2	Education formal & informal	Education formal					
INSTITUTION 3	1.Medical	1.Medical	2.Medical	2.Medical	2.Medical		
AGENCY	Legal	Legal	Legal	Legal	Legal		

***Each column represents a specific profile of person in need (or a type of case) and the map used to identify services to each profile.

TOOL:
REGIONAL SAFE SPACES NETWORK ONLINE MAP



To access the online map, please visit: **https://arcg.is/0TvXnn**
A version in Spanish is also available: click the hyperlink in the upper-right corner on the site “Spanish Version”.

TOOL: GUIDANCE NOTE ON THE REGIONAL SAFE SPACES NETWORK MAP

In the context of the Regional Safe Spaces Network, a map was created to be able to quickly and securely identify the different services that are offered in the region. This map provides the geographical location of those partner agencies and allied organizations that are part of the Network. This map is intended to be used exclusively among network members; therefore, its confidentiality must be maintained. The designated users of this map are ultimately the focal points from each organization member of the Network.

The online platform for the map contains several tabs, each dedicated to one of the service categories. To consult any particular category, the user needs to click on its respective tab to view the corresponding results on the map. The user can navigate the map by clicking and dragging the screen, or alternatively by using the zoom features located at the top left hand corner of the map to zoom in/out on a particular location. Once a location has been pinpointed, clicking on its icon will prompt: name of the organization, description of services provided, contact details, and the focal point contact details and address (if available).

The first tab, RSSN locations, displays all the cities where active members of the RSSN are established or provide services. Likewise, there are also tabs for the locations of *UNHCR Focal Points and Allies*, respectively.

There are six service categories identified: 1) Mental Health and Psychosocial Support; 2) Legal Assistance; 3) Medical or Health Services; 4) SGBV (Sexual and Gender Based Violence) and CP (Child Protection) Case Management; 5) General Protection Outreach Services and Referral, and 6) Safety. In the tab of each service category, the user can view all the available institutions that provide such service on the map. Moreover, under the profile of each institution, the user will be able to view the entire list of services offered by that institution, regardless of the tab the user has selected.

THE REGIONAL SAFE SPACES NETWORK

The Regional Safe Spaces Network (hereinafter RSSN "the Network") was established in the Americas region with the support of the UNHCR's Regional Legal Unit of the Americas Bureau, and particularly its Sexual and Gender-based Violence (SGBV) and Child Protection (CP) team (hereinafter "RLU SGBV/CP"). The Network coordinated by the RLU SGBV/CP led the development and implementation of a regional protection strategy to address the needs of the populations displaced by violence and persecution. In consultation with partners and communities the Network focused on improving access to services for survivors of SGBV, children and LGBTI people with protection needs. The Network developed common standards and tools to promote cross-border coordination in the region. At present, more than 50 organizations providing services in seven different countries (Costa Rica, Guatemala, Mexico, Colombia, Venezuela, Peru and Chile) are members of the Network and it is expected that new members and countries will join it in the coming months.

June 2018

Attention: Each focal point is asked to review the address in which the partners are being placed and if they are providing adequate service(s).

These **six categories** have been used to group the different activities carried out by the Network members and to simplify the search for services.

1. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)[1]:

Mental health and psychosocial support (MHPSS) is a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. This includes intervening to: i. Facilitate access to basic services; ii. Family and community support; iii. Focused, non-specialized support. For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. It includes psychological first aid (PFA) and basic mental health care provided by primary health care workers; iv. Specialized service, including psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacity of existing primary/general health services.

2. MEDICAL OR HEALTH SERVICES:

All activities that require medical attention (particularly provision of clinical management of rape (CMR) and sexual and reproductive health (SRH)).

3. LEGAL ASSISTANCE:

Interventions related to legal protection of SGBV survivors, children at risks, and vulnerable population, as well as for refugee and migration procedures. This can include group and individual counselling, advocacy and legal representation.

1. IASC Guidelines on MHPSS in Emergency Settings 2007

4. SEXUAL AND GENDER BASED VIOLENCE (SGBV) AND CHILD PROTECTION (CP) CASE MANAGEMENT:

It involves an organization taking the responsibility to ensure that the affected individuals are informed of all options to them and that protection risks and issues are identified and followed up in a coordinated manner by relevant actors and service providers. This category includes case recording, incident classification, case planning and implementation, monitoring and review, and case closure. Also, this service entails activities related to procedures that involve the Best Interests of the Child, for example, Best Interests Assessment (BIA) or Best Interests Determination (BID).

5. GENERAL PROTECTION OUTREACH SERVICES AND REFERRAL:

All services concerning the provision of basic protection information, guidance, and referrals to service providers matching the needs of refugees and other people on the move.

6. SAFETY:

These services are intended to ensure the physical safety of survivors, children at risk, and other persons affected by serious human rights violations. It includes safe shelters, community-based options, and relocation services.

Finally, the last layer, **allies**, refers to organizations that provide active support to the RSSN without participating in all its core activities.

N.B. Some members have decided not to share their exact location for security reasons. For these members, a geographical point relative to the city where they provide services was indicated on the map without disclosing any additional details.

REGIONAL SAFE SPACES NETWORK STANDARDS

TOOL: TERMS OF REFERENCE

UNHCR
The UN Refugee Agency

Regional Safe Spaces Network (RSSN) Americas
In [name of geographical area, country name]

TERMS OF REFERENCE

BACKGROUND

In a context of high human mobility, many people who are **survivors of sexual and gender-based violence (SGBV), children at risk and other vulnerable individuals** do not have clear information about the consequences of violence and how to access urgent care or other services. This situation is intensified when it comes to women, girls, boys, LGBTI[19] persons, and people with disabilities (PWD), and individuals with other specific needs. For this reason, the Regional Safe Spaces Network (RSSN) works in partnership with civil society, humanitarian and government organizations, national and local institutions, both public and private, as well as UNHCR Offices with the goal of bringing together and improving the services available to SGBV survivors, children at risk, and other individuals affected by serious human rights violations.

UNHCR and other partner agencies are currently engaged in regional efforts to strengthen the **Safe Spaces[20] Networks**, which provide SGBV/Child protection, targeting refugees,

19.Lesbian, gay, bisexual, transgender, intersex persons or persons with diverse sexual orientation or gender identity (SOGI)

20. A Safe Space is a kind of physical or mobile space, where groups or individuals can feel "safe", build social networks, express and entertain themselves, while accessing protection and assistance, and other services included in the Essential Package of SGBV/CP services in accordance with the age, gender, diversity and survivor-centered approaches, and the child's best interests principle. The personnel of safe spaces are aware of SGBV/CP and humanitarian principles and treat survivors and individuals at risk of SGBV, children, and people with specific needs with respect and compassion to facilitate disclosure and identification of SGBV incidents and other violations of human rights without discrimination. Safe spaces work in a network to provide referrals to specialized services, or conduct community outreach or awareness-raising activities, in a harmonized and coordinated manner with asylum-seekers, refugees, IDPs, returnees, people on the move, stateless and other people who might be in need of international protection.

asylum-seekers, internally displaced persons, returnees, persons on the move, and stateless persons, as well as other persons in need of international protection along the displacement cycle.

The Regional Safe Spaces Network (RSSN) facilitates the disclosure and identification of SGBV incidents, child protection risks, and other serious human rights violations. It aims to ensure that an Essential Package of services is provided to survivors of SGBV, children at risk, and other vulnerable population by increasing its accessibility at any particular location, or through activities such as awareness-raising. Such provisions of services must be guaranteed in a manner that underscores a survivor-centered approach, the child's best interests principle, and the age, gender and diversity (AGD) approach in order to foster an environment free of discrimination and persecution, and one that promotes inclusion and access to specialized protection as outlined in this document.

OBJECTIVES OF THE SAFE SPACES NETWORK

The Safe Spaces Network (RSSN) aspires to:

A. Identify organizations that exist in a geographic area that promote the Essential Package of services accessible to SGBV survivors, children at risk, and other persons of concern. This package includes:
   1) SGBV/CP case management for adults and children, including best interest procedures;
   2) Mental health and psychosocial support (MHPSS);
   3) Medical or health services, in particular sexual and reproductive health services;
   4) Legal assistance in order to access justice and other legal procedures;
   5) Safety, whether in shelters or through community-based solutions;
   6) Family tracing and reunification;
   7) Alternative care when needed;
   8) Education.

B. Implement services and activities that favor the disclosure and identification of SGBV incidents, child protection risks and other violations of human rights in a context of high human mobility, promoting an environment of safety and well-being.

C. Support the empowerment and resilience of survivors, children at risk, and other vulnerable population as a fundamental element of the recovery process through the reestablishment of community networks and access to psychosocial resources.

D. Establish and maintain referral pathways in accordance with the principles of confidentiality and the respect for the wishes and needs of the survivor, child or other vulnerable person. Through specialized SGBV/CP case management, referral and care within the Safe Spaces Network (RSSN), ensure access to predictable and better quality services at local, national and transnational level.

MAIN ACTIVITIES OF THE SAFE SPACES NETWORK (RSSN)

1. Coordination of prevention and response to SGBV, CP and other serious protection risks within the Safe Spaces Network;
2. Analysis of SGBV ,CP and cross-border protection trends in the areas covered by the Network and also of the achievements and gaps in service provision;
3. Development of a joint work plan, including the development of tools, policies and strategies on prevention and response to SGBV, within the Safe Spaces Network, assessments of the needs and capacities of the affected population, training and awareness-raising plans, and exchange of information within the Safe Spaces Network;
4. Training sessions can be carried out using a variety of methodologies, including workshops, informative sessions, specialized training sessions, or lectures, among others. Such training sessions may be organized and facilitated by members of the local Network using their Safe Spaces or by an external person of the Network depending on the available resources;
5. Development of awareness-raising materials on the principles, risks and consequences of SGBV, CP and other violations of human rights, as well as on the services available through the Safe Spaces Network, aimed at both humanitarian agencies and service providers as well as communities affected by mobility;
6. Exchange of policy information and protection tools as well as transfer of data on individual cases is in accordance with UNHCR's data protection guidelines and other applicable international and national standards;
7. Promotion of the concept of Safe Spaces in the different service delivery areas, including donors, governments, coordination mechanisms and humanitarian and development agencies among others;
8. Coordination with other coordination mechanisms at local, national and regional levels;
9. Other joint activities organized by the coordination mechanism.

NETWORK PARTNERS

The Network will consist of organizations providing services through both physical and mobile Safe Spaces, or Protection Spaces, that:

1. Work in a network with refugees, asylum-seekers, internally displaced persons, returnees, in transit, stateless or other persons in need of international protection found throughout the displacement cycle.
2. Provide one or more of the services in the Essential Package of services for SGBV survivors, children at risk, or persons of concern or make referrals to those services in accordance with a survivor-centered and age, gender and diversity approach and in line with the best interests of the child principles.

The inclusion of other members of the group will be considered according to the criteria and principles established by the Safe Spaces Network.

FREQUENCY AND LOCATION OF COORDINATION MEETINGS

The Safe Spaces Network, or Protection Network, will meet each [month] in a space identified at the end of each meeting. At regional level meetings will be regularly held via Webinar.

CO-COORDINATION AND COMMUNICATION

UNHCR [and name of co-coordinating organization] will be responsible for the coordination and communication between the organizations that comprise the Network. The designated focal point will communicate the agenda of the meeting and the place at least [one week] ahead of the meeting.

TERMS OF REFERENCE REVISION

[Annually], the Network will include as an agenda item the opportunity to develop a revised Terms of Reference in order to reflect changes in the context or situation of the organizations.

TOOL: REGIONAL SAFE SPACES NETWORK CHECKLIST – SELF AUDIT

COUNTRY .....

DATE .....

WHAT is the Regional Safe Spaces Checklist?

The purpose of this checklist is to assist organizations in conducting a self-audit of their existing Safe Space(s)[21] for survivors, children at risk, and other individuals at risk of SGBV or other serious human rights violation who are refugees, asylum-seekers, returnees, internally displaced persons, returnees, people on the move, stateless people and other persons who might be in need of international protection including women, girls, men and boys, and LGBTI[22] persons. The anonymous compilation of data collected by the members of the RSSN with this checklist will be used to assess the progress made at regional level.

WHO does the checklist apply to?

Organizations responsible for operating a physical or mobile Safe Space(s)[23] in a stand-alone facility or inside of another facility can use one checklist to self-assess progress and improvements made over time for locations, facilities, programs, staffing and specialized services provided to refugees, asylum-seekers, returnees, internally displaced, people on the move, stateless people, and other individuals who might be in need of international protection. Safe Spaces Networks can compile the data collected with the checklist by their members to develop joint work plans.

21. A **Safe Space** is a kind of physical or mobile space, where groups or individuals can feel "safe", build social networks, express and entertain themselves, while accessing protection and assistance, and other services included in the Essential Package of services in accordance with the age, gender, diversity and survivor-centered approaches, and the child's best interests principle. The personnel of safe spaces are aware of SGBV, CP and humanitarian principles and treat survivors and individuals at risk of SGBV, children at risk and other vulnerable population with respect and compassion to facilitate disclosure and identification of SGBV incidents and other violations of human rights without discrimination. Safe spaces work in a network to provide referrals to specialized services, or conduct community outreach or awareness-raising activities, in a harmonized and coordinated manner with asylum-seekers, refugees, IDPs, returnees, people on the move, stateless and other people who might be in need of international protection.
22. Lesbian, Gay, Bisexual, Transgender and Intersex. Diverse sexual orientation and gender identity (SOGI) is used with a similar meaning.
23. Unless otherwise indicated, all the activities in this checklist apply to both, physical and mobile Safe Spaces.

WHERE to use the checklist?

The checklist can be used by members of Safe Spaces Networks in different geographical areas affected by mixed migration flows and/or displacement where persons of concern to UNHCR may be in their country of origin, in transit, or in a destination country.

WHEN to use the checklist?

The checklist measures specific Safe Spaces criteria for individual organizations and Safe Spaces Networks to check at regular intervals (i.e. 3 months, 6 months, 1 year, etc.). The Safe Space Checklist is calibrated on an indexed scale and can be used to create baseline data and subsequent data points to compare over time. Data collected by the national Safe Spaces Networks can be compiled in an anonymous manner to produce Regional Safe Spaces Network statistics.

A = in place B = partially in place C = not in place

REGIONAL SAFE SPACE NETWORK CHECKLIST (SELF-AUDIT)

1	SURVIVOR-CENTERED APPROACH	A	B	C
a.	Services and information on available services in other safe spaces in the network are offered to individuals at risk without discrimination			
b.	Activities are conducted in consideration with the Age, Gender and Diversity (AGD) approach			
c.	Activities support a survivor-centered approach treating all persons involved with dignity and respect for the wishes of the survivor			
d.	Referrals are provided only with the informed consent and assent of the survivor			
e.	The space provides a safe and supportive environment to survivors or individuals at risk of SGBV			
f.	Private spaces and one-to-one discussions are used to conduct SGBV sessions, assessments and counseling sessions			
g.	SGBV information shared by survivors, their families or other community members is kept confidential			
h.	The organization has conducted a participatory assessment with persons of concern from different ages, genders and backgrounds			

2	FACILITIES AND ACCESSIBILITY	A	B	C
a.	The safe space is accessible to persons of concern from different ages, genders and backgrounds			
b.	The location of the safe space is accessible to disabled women, girls, boys, men, and LGBTI persons			
c.	The location of the Safe Space is accessible to indigenous women, girls, boys, men and LGBTI persons			
d.	The safe space provides locking bathrooms			
e.	The safe space provides separate communal bathrooms for women and men, as well as family /unisex bathrooms			
f.	The safe space has sufficient supplies and logistics support to deliver services for all the average number of beneficiaries			
g.	For physical safe spaces, a large space is available inside for group activities			
h.	For mobile safe spaces, group activities are organized in safe and accessible locations in coordination with the community or public services as appropriate			
i.	A shaded outdoor space is available for group activities for both, mobile and physical safe spaces			
j.	The safe space has ensured community involvement in planning of spaces (safety, sleeping arrangements, latrines, common spaces, etc.) in accordance with AGD approach			
3	**AVAILABILITY OF MULTI-SECTORAL SERVICES**	**A**	**B**	**C**
	The following services are available to survivors, children at risk, or other victims of serious human rights violation at the mobile or physical safe space or through referrals or outreach activities within the safe spaces network:			
a.	• SGBV/CP case management (CM) (collaborative and systematic process for referrals, including Best Interest Procedures for children)			
b.	• Mental Health and Psychosocial Support (MHPSS);			
c.	• Medical or health services (including Sexual and Reproductive Health services and Clinical Management of Rape—CMR);			
d.	• Legal assistance;			
e.	• Safety services (e.g. safe referrals to law enforcement);			
f.	• Family tracing and reunification;			
g.	• Aternative care arrangements;			
h.	• Education.			
i.	Services are available to LGBTI survivors or at risk of serious human rights violations			

j.	Services are available to child survivors at risk of serious human rights violations (girls and boys)			
k.	Recreational activities and events are available to beneficiaries of the safe space			
l.	Water, soap and female hygiene materials are available to the beneficiaries of the safe space			
m.	Informational activities on different topics relevant to persons in need of international protection take place regularly in the safe space			
n.	Affected populations using the safe space are consulted to determine the topics and best times for activities			
4	**AWARENESS-RAISING AND COMMUNITY OUTREACH**	**A**	**B**	**C**
a.	Awareness-raising interventions on core principles and available services within the network are conducted with survivors, children and individuals at risk of SGBV or other serious human rights violation, their families and communities			
b.	Information on protection, basic and specialized services available in the network is provided along the displacement route in all different phases			
c.	Services are made available through hotlines; offline and online communication means in consideration with AGD principle			
d.	Awareness-raising on sexual and reproductive health issues takes place in the Safe Space or in the community, in accordance with AGD approach			
5	**COMPLAINT MECHANISM**	**A**	**B**	**C**
a.	An anonymous community-based complaint mechanism is in place and known to members of the community and POC using the Safe Space			
b.	The safe space coordinates with the PSEA (Protection from Sexual Exploitation and Abuse) Network			
6	**AWARENESS-RAISING AND COMMUNITY OUTREACH**	**A**	**B**	**C**
a.	The organization is a member of the Regional Safe Spaces Network with available services for SGBV survivors, children at risk or other vulnerable population			
b.	The organization participates in regular Protection coordination meetings with national institutions, international agencies and organizations			
c.	The organization is part of other multi-functional coordination mechanisms			

7	PERSONNEL AND ORGANIZATIONAL STRUCTURE	A	B	C
	Each staff member working at or with the safe space:			
a.	• was hired using a transparent process in accordance with the organization's rules;			
b.	• was hired in line with an Age, Gender and Diversity (AGD) approach used within the organization to manage human resources;			
c.	• went through a reference check;			
d.	• has clear reporting lines;			
e.	• has standardized TORs with clear roles and responsibilities.			
f.	Volunteers and communities are part of service provision chain			
g.	Supervisors ensure adequate workload of case workers			
h.	All staff and volunteers are sensitized on working with persons of concern and survivors of or at risk of SGBV, children at risk and other vulnerable population and how to conduct referrals to other services with the consent and assent of the survivor			
i.	Mentoring, coaching and capacity building activities are regularly available to staff and volunteers in the Safe Space			
j.	Safe space's personnel understand human rights and humanitarian principles			
k.	Safe space's personnel sign, understand and uphold a code of conduct			
l.	Self-care procedures are in place			
8	**CASE MANAGEMENT (CM) FOR SGBV SURVIVORS, CHILDREN AT RISK AND OTHER INDIVIDUALS OF CONCERN**	**A**	**B**	**C**
a.	Safe space's personnel facilitate disclosure and identification of SGBV incidents and other protection risks occurred to women, girls, men, and boys, LGBTI individuals, people with disabilities (PWD), and other individuals with specific needs			
b.	Safe space's personnel and community members are aware of SGBV/CP core principles and available services			
c.	Safe space's personnel support the development and maintenance of referral pathways for case management and multi-sectoral services			
d.	SGBV/CP referral pathways including SGBV/CP case management organizations in the area covered by the respective Safe Space Network are known by the safe space's personnel			
e.	Referrals and case management services are provided in accordance with the survivor-centered approach			

f.	Referrals and case management services are provided in accordance with the Child's Best Interests principle			
g.	Referrals and case management services are provided in accordance with the Age, Gender and Diversity approach			
h.	Child survivors have access to Best Interest Procedures (BIA/BID)			
i.	Case management is provided in close coordination with relevant service providers			
j.	Case management conferences[24] are convened by the lead case management organization in the area covered by the respective Safe Spaces Network			
k.	Safe space's personnel participate in case management conference as relevant and appropriate			
9	**MONITORING AND EVALUATION**	**A**	**B**	**C**
a.	Community feedback surveys or consultations are used to help assess quality of services			
b.	A monitoring and evaluation plan that includes community participation is in place			
c.	Selected staff members are trained in program monitoring			
d.	Regular monitoring of activities and quality of service provision takes place			
e.	Timely feedback is provided to persons of concern in safe spaces who provide information for programming purposes			
f.	Indicators are available to measure performance of staff and impact of services			

24. **Case management conferences** (also called case conferencing) are meetings held to review individual cases requiring an inter-agency response, with focus on addressing any immediate protection problems and coordination response actions for each individual case. Case conferencing is sometimes needed and is more formal than case planning or review meetings. It is usually only used in very complex cases. It attempts to explore multi-sector / interagency service options and to make formal decisions in the best interest of the client. Minutes are taken, and client can be invited to participate in some meetings but not all. (Adapted from the Child Protection Case Management Training Manual for Case Workers, Supervisors and Managers. Case Management Task Force, Amman, Jordan 2014.)

TOOL:
SGBV DISCLOSURE IN FORCED DISPLACEMENT

Original Source: THE SILENCE I CARRY, Disclosing gender-based violence in forced displacement- GUATEMALA & MEXICO- Exploratory Report 2018

HUMAN RIGHTS CENTER
UC Berkeley School of Law

UNHCR
The UN Refugee Agency

REGIONAL SAFE SPACES NETWORK

THE SILENCE I CARRY

Disclosing gender-based violence in forced displacement
GUATEMALA & MEXICO • Exploratory Report 2018

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ACRONYMS AND ABBREVIATIONS

AGD	Age, Gender, Diversity
BIA / BID	Best Interest Assessment / Best Interest Determination
CM	Case Management
CMR	Clinical Management of Rape
COMAR	*Comisión Mexicana de Ayuda a Refugiados* (Mexican Commission for Assistance to Refugees)
CREAW	Center for Rights Education and Awareness (Kenya)
HRC	Human Rights Center
IDP	Internally Displaced Person
INM	*Instituto Nacional de Migración* (National Migration Institute)
IOM	International Organization for Migration
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MHPSS	Mental Health and Psychosocial Support
MSF	Médecins Sans Frontières (*Médicos Sin Fronteras*, Doctors Without Borders)
NGO	Non-Governmental Organization
PoC	Persons of Concern
PSEA	Protection from Sexual Exploitation and Abuse
PWD	People with Disabilities
RISP	Regional Information Sharing Protocol
RLU	Regional Legal Unit
RSSN	Regional Safe Spaces Network
SGBV	Sexual and Gender-based Violence
SNDIF / DIF	*Sistema Nacional para el Desarollo Integral de la Familia* (National System for Integral Family Development)
SOGI	Sexual Orientation and Gender Identity
UNHCR / ACNUR	United Nations High Commissioner for Refugees / *Alto Comisionado de las Naciones Unidas para los Refugiados*

EXECUTIVE SUMMARY

Over half a million displaced people journey north from Central America and through Mexico every year. Many suffer multiple forms of sexual and gender-based violence (SGBV), including rape, transactional sex, forced prostitution, sex trafficking, and sexual assault. Though few reliable statistics exist, different studies estimate that 24% to 80% of women suffer some form of sexual violence *en route*, along with 5% of men and 50% of gay and transgender individuals.[1] And yet very few survivors report the harm they have suffered.

One key to improving detection of and response to SGBV among refugees and migrants traveling through Central and North America is to better enable survivors to disclose, or reveal, their experiences of SGBV to service providers and others who can help. However, enabling SGBV disclosure in this context is not as simple as it sounds. High levels of mobility and regional insecurity, along with individual, social, and structural factors, can affect a person's capability, opportunity, and motivation to report this kind of harm. Additionally, it may not always be appropriate for some providers to pursue SGBV disclosure when they have such limited time with fast-moving refugees and migrants or cannot make meaningful referral to additional support services.

At the invitation of UN High Commissioner for Refugees' Regional Legal Unit (UNHCR - RLU) for the Americas Region, the Sexual Violence Program of the Human Rights Center (HRC) at the University of California, Berkeley, conducted a pilot project to assess challenges and strategies related to SGBV disclosure among refugees and other migrants in Central America and Mexico. HRC focused on Mexico and Guatemala, two countries in which UNHCR has established a Regional Safe Spaces Network (RSSN) of service providers.

This preliminary inquiry addressed two issues: a.) how to strengthen providers' approach to SGBV disclosure and b.) how to improve awareness raising about SGBV risks and support services. From September 2017 through January 2018, HRC's Sexual Violence Program conducted desk research, a field mission to Guatemala and Mexico, and data analysis using qualitative coding software. In February 2018, HRC delivered an internal report to UNHCR with preliminary findings, analysis, recommendations, and a dozen draft tools to improve SGBV-related disclosure and outreach for the Central American and Mexican context.

HRC's preliminary findings clarified how SGBV disclosure requires a multifaceted approach in a complicated context of high mobility, high insecurity, and high diversity of displacement profile, SGBV experience, and survivor identity. Findings also highlighted the need for a context-specific and coordinated communications strategy about SGBV risks and support services in order to reach refugees and other migrants traveling rapidly or far off the beaten path. In response to these results and based on its previous research on SGBV-related interventions, HRC produced several draft tools for UNHCR review and adaptation.

HRC's draft tools included a typography of SGBV disclosure from a service provision standpoint, along with training modules and sample "do's and don'ts" for facilitating disclosure in ways that consider providers' capacity and role with respect to SGBV response. Specific communication tools offer suggestions both for in-person strategies, such as facilitated group discussions and community theater productions, and broader outreach campaigns such as the strategic distribution of printed materials and creative use of public space.

Recommendations from this pilot project include:

SGBV Disclosure

1. **Take a multifaceted approach to SGBV disclosure, both as a concept and practical reality.** Consider how to prepare for "self-motivated" SGBV disclosure, how to create a safe and supportive environment that can "enable" SGBV disclosure, and whether it is appropriate for anyone on staff to "probe" for disclosure. Think beyond formal interview-based disclosure, which can be quite rare in contexts of rapid mobility.

2. **Train *all* staff members on SGBV, disclosure, and referral pathways.** Sensitization of staff to SGBV and full staff engagement in detection and response increases the potential access points a migrant or refugee may have to come forward about SGBV.

3. **Continue developing context-specific guidance on the creation of safe, enabling environments.** Guidance can address practical and structural aspects of creating a safe environment (eg, decoration of a physical space, gender-diverse staffing), as well as behavioral and communication tips for staff (eg, taking casual breaks with shelter residents).

4. **Facilitate group activities to broach SGBV.** Group activities can open up awareness and conversation about SGBV and indicate a service provider's receptivity to SGBV disclosure.

5. **Create consistent opportunities for one-on-one interaction with refugees and migrants.** Creating routine opportunities for one-on-one discussion and unstructured social time (eg, regular chores, check-ins, or other informal interactions) can build familiarity and rapport that may increase some migrants' and refugees' willingness to ask for help.

Awareness raising

6. **Establish national or bi-national SGBV hotlines in Mexico and Guatemala.** A single bi-national hotline service, or two national hotline services coordinated between countries, could provide a consistent and centralized resource for SGBV survivors, connecting or referring callers to relevant actors in both Mexico and Guatemala.

7. **Consult migrants, refugees, and service providers when developing printed materials about SGBV and the Regional Safe Spaces Network; seek their input regarding dissemination strategies.** Their input is critical when designing effective communications strategies about SGBV, particularly in a displacement context characterized by a.) diverse identities and abilities, b.) conservative norms regarding gender, SGBV, sexual and reproductive health, c.) rapid and evolving movement, d.) diverse displacement profiles, e.) legal and social insecurity and protection needs, and f.) physical insecurity and protection needs.

8. **Make creative use of common areas and public spaces.** Examples include creating SGBV-focused murals or billboards near the roadside, train tracks, or major crossing points, or offering dramatic presentations in safe spaces where migrants and refugees gather.

9. **Build on what exists: expand general outreach mechanisms to include SGBV.** Expand existing communications initiatives about refugee rights or the asylum system to also address SGBV (as with UNHCR's Jaguar campaign). Encourage local actors engaged in supporting migrants and refugees generally to include SGBV-related messaging and referrals in the course of their regular work and outreach.

10. **Develop a coordinated SGBV outreach campaign across countries of origin, transit, and destination in the region jointly with the Regional Safe Spaces Network.** Consider ways in which information disseminated in countries of origin and return, transit countries, and countries of destination can be coordinated for maximum reach, coherence and impact. This includes messaging about SGBV-related risks, rights, and resources.

General

11. **Tailor approaches to diverse refugee and migrant populations.** Risk factors, SGBV disclosure inhibitors, support needs, and effective outreach strategies may differ based on a survivor's age, gender, or sexual orientation; they may also be complicated by a migrant's or refugee's physical or legal insecurity at any point of his or her journey.

12. **Find and use the right language.** To maximize the clarity of all communications about SGBV, providers should consult targeted populations about common terms used to describe sex and violence, as these may differ based on age, gender, sexual orientation, country of origin, etc.

13. **Strengthen coordination of SGBV services in Mexico and Guatemala.** Providers should explore ways to establish a multi-country case management system with shared, secure data management and coordinated referral mechanisms. The Regional Safe Spaces Network can be a starting point for building out cross-border coordination.

14. **Develop feedback and complaint mechanisms to improve SGBV-related service provision.** Service providers should develop ways to obtain the input of refugees and other migrants regarding the effectiveness of their approaches to SGBV. This includes developing a reporting mechanism to hold providers accountable for their services and referrals.

15. **Prioritize staff well-being.** Employers should provide self-care trainings, regular check-ins, and internal support measures to uphold staff well-being.

16. **Conduct further research.** This exploratory inquiry is only a pilot project. Much more in-depth research is necessary to better understand SGBV disclosure and to develop effective awareness raising campaigns in forced displacement settings. Priority questions for further research include: What are migrants' and refugees' priority services regarding SGBV? What information about SGBV do diverse groups of migrant and refugee populations want, when?

This is the public version of HRC's initial internal report, now jointly released with UNHCR. Later in 2018, HRC and UNHCR will work with members of the RSSN to prioritize and adapt these draft tools for local practice throughout the Americas region. Though time was limited in this pilot project, it is our hope that these initial findings, tools, and recommendations will spur broader and deeper thinking about SGBV disclosure in forced displacement settings generally. We hope that this, in turn, leads to improved protection and support across the globe.

INTRODUCTION

With alarming levels of suspected sexual and gender-based violence (SGBV) suffered by refugees, internally displaced persons, and other forced migrants all over the world, it is imperative for the UN Refugee Agency (UNHCR) and its partners to strengthen its ability to detect and respond to SGBV in its populations of concern. Better SGBV identification and response require a better understanding of how to enable SGBV disclosure in the first place. However, this is not as simple as it sounds. Practical and logistical strategies might vary based on context: opportunities for SGBV disclosure in a protracted camp setting are not the same as those for a population on the move; motivation to report SGBV may differ depending on what services are available or who the perpetrator is.

There is a good deal of literature about developing effective SGBV detection and response systems in forced displacement contexts.[2] Very little of it, however, focuses on the gateway matter of "disclosure." Much of the existing literature on "disclosure" focuses on situations occurring outside of forced displacement contexts, including revelations of domestic violence or sexual assault,[3] of HIV positive status,[4] or of sexual orientation.[5] These diverse studies highlight several ways that disclosure of potentially stigmatizing experiences or identities may occur: directly or indirectly; all at once or progressively; through a one-on-one intake or in a group setting; formally through systematic screening or informally through revelation to family or friends. [6] Overall, it seems clear that complex layers of individual, social, and structural factors can affect a person's capability, opportunity, and motivation to report harm.

For the purposes of this pilot project, "disclosure" refers to the act of a survivor revealing his or her past experience(s) of SGBV in the context of service provision during forced displacement.

The especially challenging Central American displacement context, with high levels of mobility, regional insecurity, instances of SGBV,[7] and other serious protection incidents,[8] requires deeper analysis of how to safely and ethically enable SGBV disclosure among populations of concern. What can be done where a provider may only have one brief visit with a survivor who is on the move? What ethical considerations can arise when seeking SGBV disclosure in the absence of meaningful support services or witness protection?

Finally, some refugees and migrants moving through Central America and Mexico may never reach a service provider's door to begin with. For these cases, outreach and communications strategies are key: what information about SGBV do highly mobile or invisible refugee populations need? How can it be provided safely? Literature on service provision to mobile populations more generally is scant; we see little aside from a few examples in southern Africa.[9] Research on general information sharing with mobile migrant and refugee populations is also limited, with a few examples of interventions emerging from the recent rapid movement of displaced people through the Balkans and Europe.[10]

Project Background

In June 2017, UNHCR developed a cross-border Regional Safe Spaces Network (RSSN) to improve the disclosure, identification, and response to SGBV and other human rights violations for displaced people on the move through Central America and Mexico. The network aims to provide an essential service package through multi-country cooperation adapted to individuals' differing needs at every point of the displacement cycle. The "displacement cycle" refers to four phases of displacement (origin, transit, destination, return) in which refugees and migrants may find themselves. Needed services and opportunities for support may vary at different moments of the displacement cycle, requiring service

providers to understand the risks and needs associated with the different phases, and necessitating coordination among providers in origin, transit, destination, and return countries. Since its inception, the RSSN has developed several cross-network tools to ensure safe access to services for the most vulnerable populations forced to move within and across countries. This includes an online RSSN services mapping tool that traces the various shelters and resources available throughout the region, and a self-audit checklist to enable shelters and service providers to assess the quality and capacity of their initiatives to provide survivor-centered case management and other related services.

In coordination with UNHCR's Regional Legal Unit (RLU) for the Americas Region, the Sexual Violence Program of the Human Rights Center completed an exploratory mission to identify ways UNHCR and its partners can promote safe and ethical disclosure of SGBV among populations of concern in Mexico and Guatemala, two countries in which the RSSN has been established. This preliminary inquiry addresses two issues: SGBV disclosure and awareness raising about SGBV risks and support services. This pilot project included desk research about barriers to SGBV disclosure in the displacement context and a field mission to interview service providers working in the RSSN in Guatemala and Mexico. The resulting analysis suggests preliminary recommendations for enabling SGBV disclosure and improving awareness among the region's refugee and migrant population.[11]

SGBV and displacement in Central America and Mexico

Each year an estimated 500,000 people cross from Central America into Mexico, either in transit towards the United States or Canada or to seek refuge in Mexico.[12] Although men have historically constituted the majority of individuals on the move in the region, the numbers of women and unaccompanied children have been on the rise. Women represented an estimated 24% of the migrant population in 2015, up from 14% in 2011. In 2015, Mexico's National Migration Institute (*Instituto Nacional de Migración,* INM) apprehended 35,000 undocumented children in Mexico, an increase from 4,000 in 2011.[13] The number of asylum seekers and refugees in Mexico is also on the rise, with 2016 seeing a 107% increase in the number of persons of concern as compared to 2015.[14] In 2017, 40% of asylum seekers in Mexico were women, indicating an increase in the number of women fleeing persecution and seeking protection.[15]

Sexual and gender-based violence during displacement through Central America comes in many forms, including rape, transactional sex, forced prostitution, sex trafficking, and sexual assault.[16] There are few reliable statistics on violence experienced during transit through Mexico, with different studies reporting different rates. A 2013 study, for instance, estimated that 6 out of 10 women are raped during their journey.[17] Other reports from service providers in the field estimate that 8 in 10 women are raped or experience some other form of sexual violence.[18] However, other research estimates the rates of sexual violence, defined broadly, at 24% for women, 5% for men, and 50% for gay and transgender migrants and refugees.[19]

Desk research indicates that women take precautions to decrease risks of SGBV while in transit through Central America and Mexico, including traveling in less visible ways than men. Women rely more frequently than men on transnational networks to support the planning, undertaking, and financing of their journey, and more frequently hire smugglers.[20] Women are also more likely to: avoid traveling onboard *La Bestia*, electing instead to travel along highways via bus and cars; secure false documents; and stay in guest houses or small hotels instead of migrant shelters.[21] Moreover, one study noted an "unwritten rule" that women cannot travel alone, due to their vulnerability to kidnapping and sexual violence.[22] Consequently, women may travel with a male smuggler or "pair up" with a male migrant or refugee, often posing as a married couple. Understanding the persistent risks of SGBV while traveling north, women

attempt to minimize the physical consequences of possible rape on the road, and may take an injectable contraceptive that inhibits ovulation for three months; it is often called the "anti-Mexico shot."[23]

Whether believing themselves to be "in the hands of God" or believing that they possess no rights at all, refugees and migrants face challenges in defending themselves from SGBV.[24] Very few survivors report SGBV or seek medical or legal support; as a result, most of these crimes are never punished or even investigated.[25]

Actors seeking to provide SGBV services to refugees and migrants on the move through Guatemala and Mexico face significant challenges given these high levels of sexual violence and mobility, and low levels of disclosure or reporting. Additional service provision challenges include a lack of resources and training (eg, lack of medication, space for care, or personnel; insufficient or sporadic training; providers unaware of refugees' and migrants' right to healthcare) and difficulties in coordinating follow-up care given high mobility and insecurity.[26]

Despite these challenges, shelters, civil society organizations, local health clinics, and international organizations are actively working to improve detection and response to SGBV among refugees and migrants in Guatemala and Mexico. To this end, UNHCR and local service providers have taken measures such as creating the Regional Safe Spaces Network (RSSN); strengthening referral and coordination mechanisms; developing SGBV protocols and conducting periodic trainings with shelters, hospitals, government institutions, and other service providers across Mexico, Guatemala, and other countries in the Americas.[27]

Addressing the unique SGBV disclosure and response challenges in the North and Central American displacement context will require continued coordinated efforts from key actors, integrating awareness raising initiatives along the entire corridor with strengthened SGBV detection and response networks.

METHODS AND ACTIVITIES

The project was completed in four phases, beginning with desk research at the University of California Berkeley in the fall of 2017. From November 6-14, 2017, researchers conducted a field mission to Guatemala and Mexico during which they interviewed 41 key informants representing over fifteen relevant organizations and institutions (eg, UNHCR, local partners in the Regional Safe Spaces Network, and state authorities). Semi-structured interviews addressed existing challenges in identifying SGBV among displaced populations as well as considerations for improving disclosure and awareness raising.[28]

In January 2018, researchers analyzed field interview notes using Dedoose, a mixed methods coding software. Desk research and interview data analysis led to the drafting of this report and the development of preliminary tools to aid local service providers in approaching SGBV disclosure.

FINDINGS

Field mission findings presented here reflect perceptions and information shared by service providers and other key informants. Where appropriate and useful, researchers have integrated relevant literature in endnotes that either corroborates findings or provides suggestions for further, related reading. Findings are divided into two thematic sections: SGBV disclosure and awareness raising. Unless otherwise indicated, all findings reflect SGBV disclosure and awareness raising considerations for refugee and migrant women in particular.

SGBV Disclosure

Service providers identified multiple barriers to SGBV disclosure and expressed concern about certain safety and ethical considerations that may arise after disclosure. Thus, strategies used or recommended by service providers to enable disclosure reflected attempts to both reduce initial barriers to disclosure and mitigate its accompanying risks. This section details the barriers, ethical considerations, and strategies related to SGBV disclosure identified by key informants.

Barriers to disclosure

Informants viewed disclosure of SGBV as inhibited by multi-faceted, layered, and interconnected barriers. These ranged from personal, psychological barriers experienced by an individual survivor to larger cultural and structural factors.[29]

Cultural norms and social stigma: The most commonly cited barriers to disclosure revolved around larger cultural and social factors. Service providers commented that conservative cultural or religious environments in which sexuality or sexual violence are taboo make it difficult for women survivors to speak about their experiences, and lead them to fear being stigmatized if others were to discover what happened. Several shelter staff noted this was especially the case for indigenous women, who may talk about violence that happened to other women, but who often would not reveal that they themselves had suffered sexual violence.[30] In addition, providers noted that in the context of chauvinist cultural norms, men are not "supposed" to be victims of sexual violence, and thus may not report violence due to extreme shame or fear of stigma. For lesbian, gay, bisexual, transgender, and intersex (LGBTI[31]) survivors, disclosure of sexual violence can be interconnected with disclosure of their sexual orientation or gender identity; fearing identity-based prejudice on the part of service providers, they may be reluctant to disclose sexual violence or seek needed services.

The identity of and, potentially, a relationship to the perpetrator also emerged as an inhibiting factor, particularly for women and children. Service providers felt it was more difficult for survivors to disclose SGBV if the perpetrator was a family member, due to both the rupture of a trusted relationship and the pressure from other relatives to remain with a spouse. This difficulty in disclosure of SGBV also extended to community members, even including *coyotes* (i.e. smugglers) who came from the same hometown.

Finally, providers mentioned that some women survivors have a sense of guilt due to having assumed a risk of harm or having defied gender norms by leaving home and family in the first place.

Normalization of violence: Key informants frequently singled out "normalization of violence" as a barrier to disclosure of SGBV. This concept manifested in at least three ways. First, it seemed that survivors may

not see themselves as victims or recognize the sexual harm they suffered as violence due to the normalization and frequency of violence in the places from which they come. For instance, one social worker noted that male survivors will frequently say, "It wasn't sexual violence – I was just stripped naked and groped as part of the robbery." Second, survivors may accept violence suffered *en route*, including SGBV, as a "price" to be paid for passage through Mexico. The same sense of "assumed risk" that leads many women to take contraceptives before leaving their home countries may also make them less willing to "complain" about SGBV they suffer on the journey. Third, providers noted that widespread corruption and impunity for violence that Central Americans observed in their home countries, as well as during migration, can erode their confidence in authorities and the justice system. This lack of confidence can discourage migrants and refugees from disclosing experiences of harm including SGBV; there is simply nothing to be gained.

Trauma: Service providers frequently cited an individual's level of trauma from the incident of sexual violence as a personal, psychological barrier to disclosure. Interviewees noted that trauma makes it emotionally difficult for survivors to open up about their experience; it may make survivors wish to forget about the experience or return home, particularly in the case of children. An individual's age at the time of SGBV was also considered as a factor that could affect the experience of trauma.

Time: Time was often cited as a barrier both to disclosure and ability for follow up. Service providers noted that it can take time to open up about instances of sexual violence which, combined with the short lengths of stay at shelters, makes it difficult for survivors to disclose. Additionally, service providers mentioned that many women on the move prioritize continuing onward over receiving any sort of attention for sexual violence. Providers fear that if a survivor perceives that disclosing SGBV will slow her down, or that she will have to wait to receive assistance and services, she may be more inclined to keep quiet and continue moving.[32]

Low levels of education and lack of awareness of rights and services: Several key informants mentioned persistent low levels of education as a barrier to refugees and migrants being able to understand the systems, structures, and services available to them, thus inhibiting disclosure. Relatedly, providers mentioned that low levels of education made it difficult to explain to survivors the process and necessity of treatment and follow-up. Service providers noted migrants' and refugees' general lack of knowledge and awareness as to their own rights and services available to them, which may make them disinclined to disclose instances of sexual violence. Several key informants also noted the prevalence of misinformation: inaccurate accounts of who has the right to seek assistance for which services may deter survivors from coming forward to service providers to seek help.

Fears related to direct consequences of disclosure[33]: Service providers identified perceived risks of disclosure as barriers for coming forward. For instance, fear of retaliation from the perpetrator, fear of being identified or compromised in some way either by a perpetrator or by government authorities, and fear of the implications for one's immigration case or asylum application were all noted as security risks that deter disclosure, particularly for women and LGBTI individuals. Migrants' and refugees' potential conflation of disclosure for purposes of receiving humanitarian assistance with disclosure to authorities for purposes of filing reports and complaints emerged in interviews as a perceived risk of disclosure that could contribute to the fear of coming forward about sexual violence.

Service provider capacity and competence: Several interviewees noted that provider-side limitations could inhibit survivors' willingness to discuss experiences of SGBV. Capacity and competence limitations described by key informants include: a lack of training on SGBV, difficulty talking or posing questions about SGBV, an absence of female personnel, and a lack of private, confidential space in which to speak about these issues. For example, several providers noted problems with confidentiality, sensitivity, stigmatization and professional competency in hospital settings toward women survivors.

They mentioned stories of health workers speaking about survivors in open hallways, demeaning survivors, not knowing how to provide quality clinical services for female rape survivors, and refusing to treat migrants or refugees due to stigma or lack of awareness about their rights to healthcare in Mexico.[34]

Service providers also expressed concern that limited sensitization about specific experiences and needs of different survivor groups — including women but also extending to male and LGBTI survivors — may discourage those individuals from disclosing. For instance, some providers gave examples of hospital personnel prescribing the morning after pill to male survivors or not knowing the appropriate antibiotics for specific survivor groups. Providers noted that if migrants and refugees sense response and support services are limited, they may see no reason to reveal SGBV. Finally, negative impressions of a specific profession, which may be due to poor quality of services received, may disincline survivors from disclosing to those professionals. For example, an interviewee related a Guatemalan girl's reluctance to speak with a psychologist because "all that psychologists do is ask me questions and then they don't do anything."

Safety and ethical considerations of disclosure

In addition to barriers to disclosure, service providers expressed concern over ethical considerations that arise after disclosure, including the physical and emotional safety of survivors. Broadly, these ethical considerations of disclosure fell into one of three categories: (1) Physical and psychological harm to survivors, (2) Capacity to provide survivor-centered response, and (3) Limited uptake of services by survivors.

Physical and psychological harm to survivor: Service providers noted that disclosure could expose survivors to perpetrators, especially if subsequent reports are made to the police, who may be unable or unwilling to offer protection and prosecute crimes. If the perpetrator is an intimate partner or traveling with the survivor, both shelter staff and UNHCR personnel lamented that there are very few "protection homes" or other safe places for sheltering survivors. Options for relocating survivors within Mexico and Guatemala are limited, they noted. In Guatemala, providers emphasized a need for more "protection homes" in general, especially since women are not necessarily safe from intimate partner violence in migrant homes. In Mexico, informants commented that few domestic violence shelters accept migrants or refugees, and referral networks north of Mexico City are not yet fully functional, thus limiting the geographic possibilities for relocation, specifically in the most urgent cases.[35] Unsecured data collection systems used by organizations or the ability to locate survivors via social media could further compromise survivor safety after disclosure.

In terms of psychological harm, the majority of providers expressed concern that survivors are often obligated to re-tell the story of traumatic events, whether to different professionals working within an organization or to others as a result of referral processes between organizations for SGBV response. This can be especially traumatizing if re-telling does not lead to relief for the survivor, such as legal protection if they decide to report the violence to the police or apply for refugee status. Service providers concluded that emotional re-traumatization, impunity, and the potential of a perpetrator identifying the survivor or attacking their family in retaliation affects both their psychological and physical safety after disclosure.

Capacity to provide survivor-centered response: A lack of adequate follow up services and shortfalls in service provider capacity and competence also raise ethical considerations related to disclosure. Survivors' fears related to disclosure, such as fearing an obligation to report to authorities or fearing the limited nature of response and support services, may indeed be well-founded if SGBV response is not survivor-centered. For example, a provider noted that in Mexico, a survivor who seeks emergency medical services for sexual violence should first file a report with the *Ministerio Público,* and all

professionals are required to notify the *Ministerio Público* of any SGBV case, even if the survivor does not want to report it. In Guatemala, providers lamented that the Public Prosecutor's office and other public institutions do not know how to provide survivor-centered response for survivors of diverse gender identities, thus contributing to trans individuals' fear of approaching authorities to file SGBV reports.

Service providers additionally commented that it may not be ethical to encourage disclosure if there is a lack of nearby available services, insufficient human resources including absence of lawyers and social workers in more remote areas, or shortages of medicine and long wait times, especially given survivors' intentions to keep traveling. Providers also noted that a lack of coordination between services, not knowing who all the actors are along the route, or poor referral mechanisms between existing services raise ethical considerations related to disclosure, as survivors are at risk of re-traumatization at the hands of the referral process itself. The Regional Safe Spaces Network members in Guatemala and Mexico aim to address this concern by strengthening referral mechanisms and service coordination. Lastly, service providers noted that a lack of sensitivity toward survivors among providers, such as prejudice against migrants, refugees, women, girls, or individuals with diverse sexual orientation and gender identity (SOGI), compounded traumatization and negatively impacted survivors' emotional well-being, raising further ethical concerns of disclosure.

Limited uptake of services by survivors: Other ethical considerations of disclosure centered on an individual survivor's prerogative to refuse follow-up services after disclosure. Many providers in Guatemala noted that an unwillingness to access services is frequently due to time constraints within the highly mobile displacement context, as survivors may leave to continue their journey before the service can be provided or may be discouraged by the length of time required for follow up procedures. Providers mentioned that others refuse service due to a reluctance of being identified in a referral pathway. Additionally, providers noted that some survivors are simply unable to access otherwise desired follow-up services. For example, providers mentioned that a survivor who discloses SGBV in hopes of filing a police report may not ultimately access justice if she is unable to identify the perpetrator. Key informants also commented that some survivors may simply be so traumatized that they would prefer to return home rather than seek services.

Strategies & techniques for enabling SGBV disclosure

Service providers discussed methods used both to detect instances of SGBV and to facilitate the disclosure of SGBV.[36] To the extent possible, service providers attempted to reduce barriers to disclosure among migrant and refugee populations on the move and account for safety and ethical considerations.

Spaces of disclosure

Service providers identified several **spaces where disclosure can occur**. These can be categorized roughly into (1) physical or literal spaces and (2) contextual or circumstantial spaces. Physical spaces identified for disclosure included office settings, hospitals and clinic settings, indoor and outdoor common spaces, indoor and outdoor private settings, and churches or spiritual spaces. The circumstances in which disclosure occurred in these various physical spaces included: with medical personnel, counseling staff and social workers; with priests and nuns; with general personnel working at shelters (i.e. regular staff members other than SGBV-focused specialists or professional psychologists or social workers, e.g. kitchen staff, security guards, and volunteers); on intake questionnaires, or during intake for shelter, health, and legal services; during legal procedures such as application for refugee status and Refugee Status Determination interviews; and during group activities, such as group therapy spaces, group discussion and information sharing spaces on SGBV and migrant or refugee rights, and peer group settings without the presence of staff.

Building trust and creating safe space

Within each of these settings, service providers employed different strategies and techniques to enable SGBV disclosure. The most frequently cited methods were **building a sense of trust** and **creating a safe space.**[37] These are interrelated processes, but techniques shared by service providers can be roughly categorized into (1) interpersonal strategies and (2) organizational or structural mechanisms. These are detailed in the table below:

Interpersonal strategies for building trust:	**Organizational mechanisms for creating safe space:**
• Demonstrate empathy and compassion • Refrain from judgment, accusation, or body language that could suggest this • Practice active listening, including making eye contact, being attentive when the person is speaking, ensuring you are not distracted • Emphasize and demonstrate confidentiality (eg, by refraining from speaking with colleagues in a visible setting immediately after survivor shares sensitive information with you) • Build self-esteem by affirming a person's feelings, desires, and expressions • Pay attention to small details and help with little items to demonstrate care (eg, giving new shoelaces or playing with children) • Be honest and transparent to help build a horizontal, mutual relationship • Play games with children, and sit on the floor with them to be at the same physical level	• Ensure there are private spaces to talk one on one • Have designated dormitories at shelters for women, men, girls, boys, and individuals with diverse SOGI • Ensure that peers are available to talk with and interview migrants and refugees with diverse profiles (eg, have women and LGBTI individuals on staff, that migrants and refugees can approach) • Establish peer support groups amongst refugees and migrants • Provide the possibility for someone to tell their story, but don't push if they are uncomfortable • Create a family environment • Have a predictable daily schedule so that shelter residents know what to expect • Staff maintain daily availability for conversation by being present and accompanying shelter residents • Share other case examples of sexual violence, emphasizing that it isn't normal and there are people who can help • Assign a single person to a case (eg, one psychologist per refugee or migrant, no shifting around) • Ensure access to religious or spiritual counsel • Staff offer help with basic or emergency needs upon arrival before asking questions about someone's background and journey • Ask permission to share any information a survivor reveals and explain the purpose of sharing

One-on-one interviewing and questioning

Service providers also discussed the ways they conducted interviews to create a sense of safety and facilitate SGBV disclosure via direct questioning. Most interviewees had received training on SGBV-sensitive interviewing techniques from UNHCR and other actors, but interview findings highlighted particular strategies used during interviews to encourage disclosure.

Whenever possible and appropriate, providers attempted to converse or have small exchanges with the individual in question before the actual interview to establish rapport. With people of diverse SOGI, for instance, these exchanges may begin in online support groups. In shelters, these may be part of a welcome initiative. When the interview begins, providers mentioned they start with non-sensitive subject matter and gradually ease into asking about violent experiences. They are careful to hold the interview like a conversation, and not an interrogation, letting the individual take the lead in telling their story and asking clarifying questions when needed. In addition to employing the interpersonal techniques for building trust

outlined in the previous section, service providers also supported individuals during interviews by letting them know there was no obligation to talk in that moment, reassuring them that they are not alone and that providers are there to help, and maintaining an overall positive attitude that demonstrates warmth. Providers also mentioned the importance of creating a more balanced dynamic within the interview by giving information to individuals, either verbally or in the form of physical materials, regarding legal options, medical and psychological care, and so on.

Interestingly, service providers had a diversity of opinions regarding whether to employ direct or indirect questions during interviews. Some providers noted they do not broach the subject of sexual violence until the individual is in a therapeutic space, or until they bring it up themselves. Other providers asked questions directly, either during intake or interview proceedings. These questions included: "Are you afraid to go back home? Did anything happen on the route? Were you a victim of sexual violence?"

Some providers have created their own personalized approach to humanized questioning with refugees and migrants on the move. A particularly salient questioning strategy emerged from one key informant, who observed that people on the move often say that everything is alright in response to questions such as "how are you doing?" or "how is the trip going?" To connect empathically with the individual, she asks a follow up question, "and how is your heart?" (*Y cómo está tu corazón?).* This unanticipated question opens an avenue for speaking about one's emotions, and many migrants and refugees respond by saying they have been sad, worried, or hurting. A deeper conversation about the needs of the individual ensues, and they can be referred to proper follow up care.

Group activities and information sharing

Frequently noted were the ways in which **group activities** – whether for therapeutic purposes or as awareness raising efforts – can help enable disclosure, either during the group session or afterwards in a one on one setting. Three examples of different types of group activities were discussed.

Group therapy spaces.

- These aim to help individuals process emotional trauma, often through activities such as art therapy, discussion of feelings, or exercises to connect emotions to one's body. Providers noted that disclosure can occur during group therapy or after, when providers approach individuals who demonstrated signs of having suffered sexual violence separately to inquire further.

Group discussion and information sharing spaces on SGBV and rights.

- Most shelters held welcome sessions, informational talks and other workshops that addressed a variety of topics. Many providers noted that these group discussions helped to de-pathologize SGBV and attempted to chip away at harmful cultural norms surrounding gender, violence, displacement, and migration. In many cases, providers would detect instances of violence amongst participants by reading body language and responses. After group discussion, providers would then approach individuals one on one, or vice versa.

Peer group settings, without staff present.

- In a few instances, providers noted that shelter residents themselves would lead group activities without staff present. These peer group settings were often used to encourage newcomers to open up to an easily trusted peer. This model worked best in shelters for children or with medium-term stays, as long-term residents worked with shelter staff to detect cases.

Full staff engagement in SGBV detection and response[38]

Most service providers noted that having **all staff engaged in the process of SGBV detection and response** is crucial to facilitating disclosure and ensuring adequate follow up. Similar to previously

mentioned disclosure techniques, providers noted institutional or operational ways in which organizations can ensure full staff engagement as well as different interpersonal ways that general personnel (i.e. staff other than psychologists, social workers and lawyers) engage in SGBV detection and response.

On the operational level, providers mentioned the following strategies for ensuring full staff engagement: training all staff and volunteers on SGBV detection, response, and psychological first aid[39]; holding all-staff meetings at shelters to discuss cases and to practice questioning one's own assumptions about migrants, refugees, displacement and migration; ensuring staff is knowledgeable about refugees' and migrants' home country contexts; training staff to be aware of different profiles and risk factors of different migrant and refugee groups; and having a diversity of people on staff who can be peers to different groups of migrants and refugees, including men and LGBTI individuals.

On the interpersonal level, providers mentioned the importance of de-pathologizing SGBV by involving all staff members in open discussion of and response to SGBV with refugees and migrants, as relying solely on psychologists and social workers can make survivors feel stigmatized. In one example at a shelter in Mexico, shelter personnel mentioned that at times survivors have disclosed their case of SGBV only after building a trusting relationship with staff working in the kitchen or infirmary. In addition to communicating a general sense of trustworthiness and openness to discussing SGBV, providers noted that general personnel (i.e. regular staff members other than SGBV-focused specialists or professional psychologists or social workers) often have their own ways to enable disclosure. For example, they frequently play games with children, ask indirect questions about feelings, engage in casual conversation with migrants and refugees, and are attuned to passing comments in the kitchen, during dinner, at the front gate or during other leisure activities. Providers noted it was especially important to have men, women, and individuals with diverse sexual orientations and gender identities on staff, where possible. This would help build natural receptivity to, and connections with, many different survivors of all gender identities and sexual orientations.

Along with these acknowledgements, staff across partner organizations also recognized the challenges in achieving systematic involvement of all staff in SGBV detection and response efforts.

Specific disclosure strategies for different population groups

In addition to women, who remain the group most vulnerable to SGBV, some service providers mentioned specific strategies for encouraging disclosure with other distinct groups of refugees and migrants, such as men, LGBTI individuals, and children. Given the particular reticence of men to come forward and discuss SGBV, providers mentioned that some men may trust doctors to assist them and so should be encouraged to seek medical care if there is suspected sexual violence. Some providers noted that, ironically, it is the women traveling with men who can assist in detecting SGBV among their male counterparts. Thus providers work to build rapport with women who can help reveal any incidents of sexual violence with men in their travel group.

With refugees and migrants of diverse sexual orientation and gender identity (SOGI), providers noted there is a heightened importance of having peers engaged for encouraging disclosure. Direct community outreach by peers, such as trans women NGO workers going to speak directly with trans women sex workers, was highlighted as a key strategy for building the trust necessary for disclosure. Building trust can also begin online. For example, some providers described using online fora to start conversations with trans men who would later visit providers in person and relate their experiences of rape and forced marriage. In terms of creating a supportive environment for refugees and migrants of diverse SOGI to encourage opening up about SGBV, providers had differing views on having designated "LGBTI modules" or dormitories in shelters. Some said this is crucial to providing support and safety for LGBTI individuals, while others thought it could be stigmatizing, giving the impression that the shelter was

"putting all of them over in the corner." Finally, informants raised concerns that lesbian, gay, bisexual, trans, and intersex individuals are often lumped together in one category and not supported in accordance with their diverging needs. They lamented that this tendency subsequently renders certain groups invisible and thus more vulnerable, mentioning trans men and lesbian women in particular.

Researchers' inquiry on boys, girls, and children of diverse sexual orientation and gender identity was limited, but providers nevertheless mentioned using strategies such as playing games, drawing, and activities other than discussion to help bring out experiences of violence.[40] With adolescents in particular, providers noted the importance of direct, honest communication and transparency, as they are quick to feel trapped and suspicious of authority figures.

Disclosure and highly mobile populations

Across the board, service providers acknowledged that establishing rapport and encouraging disclosure can be a challenge with populations on the move. Some providers expressed concern about promoting disclosure of SGBV where there is a lack of available support services for referral or risk of re-traumatization or compromising survivor security. Strong coordination and effective referral pathways between different service providers along the routes of travel remained the most plausible mechanism of addressing these concerns. Thus, most service providers acknowledged the importance of continuing to strengthen UNHCR's Regional Safe Spaces Network so as to better adapt to this particular context of high mobility.

Awareness raising & communication with refugees and migrants

A second prong of inquiry focused on strategies for communicating with refugees and migrants about SGBV services and how they can seek support and protection. This inquiry emerged from a recognition that a.) migrants and refugees on the move may be unwilling to stop for help right away but could still benefit from knowing where and how to access assistance further down the road; and b.) many individuals on the move will avoid coming into contact with service providers at all, so advising them of rights, risks, and available services requires creative and diffuse outreach strategies. This section first outlines SGBV-related information that interviewees deemed useful for migrants and refugees on the move, and then details specific efforts and ideas for relating that information to refugees and migrants.[41]

Priority information on SGBV-related rights and services

Service providers and UNHCR staff shared insights about the kind of information migrants and refugees need or find useful related to SGBV. Broadly, this included the types of services available to them, the location of those services, and assurance of the right to access them. Some providers also mentioned the need to raise awareness with migrants and refugees about what actually constitutes sexual violence.

Key informants noted that migrants and refugees needed access to the following types of SGBV-related services most: post-rape care, including emergency contraceptives, pregnancy tests, STI testing, HIV testing and counseling, clinical care for physical injuries during assault, referral to psychosocial support, and forensic evaluation for those wishing to pursue legal action; other sexual violence-related healthcare, including drug and alcohol addiction support for some refugees and migrants forced to engage in sex work; asylum application support services for claims related to SGBV and sexual orientation or gender identity; support groups for past harms, whether in person or online; and SGBV-related services specifically sensitive to the differing needs of women, men, girls, boys, and individuals of diverse sexual orientation and gender identity.

Key informants also stressed the importance of migrants and refugees on the move knowing where they can safely access needed SGBV-related services. This included knowing which shelters or organizations provide those services and knowing where along the migration route those organizations have mobile clinics or other centers. Key informants noted that migrants and refugees would approach organizations if they were familiar with them and deemed them trustworthy. Informants also mentioned people's need to know the location of public hospitals and LGBTI-sensitive services.

Finally, providers noted the need for migrants and refugees to know their rights when traveling, especially once they cross an international border. This included migrants and refugees knowing about their rights once they stepped into Mexico: could they access healthcare, report SGBV crimes, obtain protection or a humanitarian visa, or apply for asylum for gender-related claims?

SGBV-specific outreach and awareness raising

Service providers shared existing efforts and ideas for SGBV-specific outreach and awareness raising initiatives with researchers. These existing initiatives and ideas broadly targeted two types of migrants and refugees: those with whom organizations had direct contact, and those who had not yet or possibly would not reach support services.

In-person strategies

Where possible, providers stressed that sharing SGBV-related information in person to refugees and migrants is most effective. Thus, many efforts were aimed at those with whom providers had direct contact. At shelters, providers hold information sessions on the risks on the road, including sexual violence, and how to seek help. Providers often share examples of sexual violence cases in transit to help survivors present during discussion understand their own experiences as sexual violence, thus opening the door for seeking help.

Providers noted additional workshops held at shelters on topics such as "social education," which seek to break down harmful gender norms and disrupt the normalization of SGBV. Workshops on domestic violence, "new masculinities," and others specific to SGBV awareness raising were also identified as helpful for teaching migrants and refugees about SGBV and thus encouraging them to seek support services. Workshops on sexuality and sexual health also figured among the strategies, both in children's shelters where staff held discussions on consent and non-violent relationships, and in faith-based shelters that promoted healthy understandings of sexuality. Despite efforts by many shelters to raise awareness about harmful gender norms via workshops, however, service providers lamented that it can be difficult to achieve any results given the short period of stay and highly mobile nature of the displacement context.

Several service providers commented on the utility of using light-hearted humor and jokes in workshops that discuss traditionally taboo subjects like sexuality, as people may at first feel uncomfortable speaking openly. Breaking workshop participants into smaller groups according to age and gender was also identified as useful for making people feel more comfortable.

For resident refugees not on the move, providers mentioned that organizing discussion groups for SGBV survivors could help promote information sharing among SGBV survivors, help reduce the risk of re-victimization in the asylum country, and encourage survivors to share SGBV-related information with women outside of the group. One informant shared an example of asylum-seeker populations in Ecuador who used these groups to foster empowerment and fight the culture of machismo, stating that the model could potentially be replicated in Mexico.

In addition to discussions and workshops, service providers took measures at shelters such as intervening to call out discriminatory comments or prejudiced behavior among shelter residents when they occurred, taking the opportunity to de-normalize harmful cultural norms. Other providers with experience in mobile clinics noted that opportunities for SGBV information sharing also arise when women directly approach medical or social services asking for the Depo Provera shot. Interviewees stressed the importance of having materials on hand and being prepared to discuss SGBV with women in these situations.

Direct outreach into specific communities was also mentioned as an in-person awareness raising strategy, particularly with LGBTI communities or others that may be at risk of SGBV or looking to flee their home country. Some providers hold weekly discussions at a safe location for those in vulnerable communities looking to learn more about international protection possibilities. For those who cannot attend such sessions, providers noted that participants will pass key information to their peers by word of mouth.

Broader SGBV outreach and awareness raising strategies

Providers briefly mentioned a few SGBV outreach and awareness raising efforts targeted at actual or potential refugees and migrants who do not come into direct contact with service providers. Many of these campaigns centered on prevention of SGBV, with some providers stressing the importance of going out into schools and communities to have frank conversations about SGBV. One provider shared an example of a local women's group in Guatemala that distributes small handouts with items listed for a "little emergency bag." Women can then have specific items ready to immediately flee any situation of SGBV. A similar "emergencies kit" was developed by an organization serving the LGBTI population.

Other providers mentioned ideas such as painting murals along the migration route targeting women on the move with messages like "rape is never ok," accompanied by a phone hotline number to call in case of SGBV. For the LGBTI community in particular, key informants highlighted the importance of having content online or support groups on social media. Some providers mentioned cases of LGBTI individuals who would message organizations with questions about access to hormone therapy, only to eventually reveal stories of sexual violence and a desire for finding help and support.

Finally, some providers stressed that awareness raising initiatives about SGBV and displacement should target other populations, such as host communities, police and law enforcement,[42] and municipal government actors, whose actions or inactions can significantly impact refugees and migrants.

Other outreach and awareness raising efforts

Informants felt that general outreach strategies, materials, and campaigns could be built upon to include SGBV-specific information and target a wider audience. They also suggested new ideas for different forms of awareness raising that could incorporate SGBV messaging.

Videos, games, and interactive methods

Some providers suggested disseminating SGBV-related information via video screenings, games, and other interactive methods. They referenced, for instance, the UNHCR's screening of informational videos about the asylum application process in shelters, community spaces, and clinic waiting rooms. Other potential games and interactive methods mentioned included writing migrant and refugee rights on cards, playing dominos while sharing information, and presenting sample scenarios to ask for appropriate responses.

Physical materials and visual advertisements

The majority of providers discussed building on existing physical materials or creating new ones to disseminate information. For example, shelters frequently pass out informational brochures, pamphlets, maps, cards, and other handouts or small materials to refugees and migrants. Interviewees suggested condensing and simplifying written materials by providing information on available services in the next town or shelter as opposed to providing large amounts of information about the entire route on a single pamphlet or flyer. Interviewees suggested that UNHCR, international organizations, shelters, and other civil society organizations incorporate SGBV messaging on the materials they generate.

Providers also mentioned the utility of murals, banners, and large posters located both in places where migrants and refugees may interact with service providers, such as shelters, hospitals, or other institutions, and in public spaces that they may pass while traveling even if they do not come into contact with providers. For example, civil society groups have painted murals and created street art in comic form placed near trains, bus stops, parks, and other public places along the route in Mexico. In Guatemalan border towns, key informants mentioned the proliferation of posters, brochures, and leaflets with information on migration. UNHCR has generated large posters with information about the right to seek asylum in Mexico, visible in public parks, detention facilities, migrant shelters, and other places along the route. Additionally, key informants mentioned magazines, newspapers and other forms of physical press as potential sources of information.

In comparing smaller materials such as flyers and pamphlets with larger ones such as murals or billboards, many providers noted that paper materials are easily lost or stolen, and that flyers heavy with text are less likely to be read than large billboards or advertisements that prioritize visuals. They commented that this is especially the case for adolescents and populations with low literacy levels. Therefore, interviewees stressed the value of using large, visual advertisements rather than flyers.

While large visuals were preferable over smaller flyers, providers noted that the presence of organized criminal groups makes it difficult to trust any type of information that is not provided face to face. If migrants and refugees are unfamiliar with the actors providing support along the route, informants noted they may still be hesitant to trust information shared on large billboards or signs, particularly if they do not recognize logos of organizations such as UNHCR and other international humanitarian agencies.

Providers further cautioned that large, public signs and murals could pose security risks to both forced migrants and service providers if specific information about shelter locations and services along the route is advertised. Informants stressed that sharing too many details about service locations could attract gang members and immigration authorities, increasing refugees' and migrants' risk of kidnapping, assault, and detention. Informants preferred sharing exact information about a place in person or via WhatsApp.

Social media, phones, and Internet

Ideas on the use of Internet and social media as a mass communication tool were mixed. Some providers stated that almost all migrants and refugees used or had access to social media, citing adolescents' use of Facebook and WhatsApp in particular. Providers noted that refugees and migrants frequently use social media to communicate with their families and contacts, both back home and in the U.S., to give updates on their journey and seek information. When they arrive at shelters, providers observed that refugees and migrants often first seek a place to charge their phones or access the Internet before seeking help for basic needs. Other key informants also noted that a web or social media page with information about human rights would help migrants and refugees with mobile phones learn how to defend themselves, and suggested that providers work with Internet cafes to ensure that refugees and migrants who may not have mobile Internet access can still benefit from web resources.

Other informants, however, emphasized that not all refugees and migrants have access to phones or social media, particularly vulnerable groups such as women and LGBTI individuals. They pointed out that many migrants and refugees are robbed of their phones along the way, and data plans and SIM cards do not necessarily transfer between countries. Social media also comes with many security risks that could endanger migrants and refugees traveling through Central America and Mexico. Several providers cautioned that Facebook uses geo-localization features on pictures, which can't be turned off, and which puts users at risk of being identified and tracked by perpetrators or gang members. Several cases were mentioned of migrants and refugees being found and murdered once already in Mexico through tracking on social media.[43] UNHCR staff stressed that they are trying to address online security concerns with their Jaguar campaign, for instance by disabling comments on Facebook pages and posting informational videos on staying safe online.

Apart from physical materials, murals, and social media, service providers mentioned other forms of popular media used to reach refugees and migrants in transit or about to leave their home countries. Radio shows and TV programming at local and national levels were cited as important means of mass communication. Particularly in remote areas and communities from which people flee, service providers suggested implementing local or indigenous language information campaigns via radio stations streamed on the Internet. Providers suggested that radio shows could build linkages in local communities between people who had left and been deported back and those who were considering leaving. They offered that returnees who had encountered violence could share their stories in local communities of origin.

Lastly, several service providers brought up the idea of a universal phone hotline. For example, providers in Guatemala are working with the Human Rights Ombudsman to launch a hotline that can serve as a "formal complaint mechanism" for human rights violations, migration issues, and issues of international protection. UNHCR staff and providers noted that hotline call workers would be equipped to refer callers to appropriate organizations within the RSSN. Providers mentioned that even with small budgets, hotlines can be effective 24 hours a day with use of informational audio recordings or SMS.

Direct outreach

An important outreach and awareness raising strategy revolved around providers actually going to places where migrants and refugees are known to travel. Providers mentioned going to airports when deported and returned individuals arrive so as to inform them immediately of available reintegration services. The importance of mobile clinics stationed along key points of the migration route was also emphasized. Similarly, the Salvadoran consulate has sent a "mobile consulate" to border towns like La Técnica in Guatemala to provide migrants and refugees with information, although key informants stressed that protection risks to refugees and asylum seekers should be evaluated with this practice. Lastly, one service provider shared the example of Las Patronas, a civil society organization that slips small materials and informational tools to migrants and refugees about available services when they encounter them on the train or at other points along the route.

Key informants noted the importance of making information available right at the border (eg, information on asylum processes, migrant and refugee rights, and services available up the road). Due to high levels of insecurity in border towns that are often controlled by gangs and cartels, however, informants stressed that information at the border should be shared in person directly from representatives of reputable, recognizable organizations. However, this same factor of insecurity raised concerns about service providers being able to safely provide direct services to migrants and refugees in border areas. Alternative suggestions for sharing information at the border included installing large-lettered billboards listing a telephone hotline number that migrants and refugees could call to seek information and assistance. Informants acknowledged, however, that this method does not fully account for issues of trustworthy information that may make migrants and refugees hesitant to come forward and seek assistance.

Building on existing campaigns

Informants shared a number of existing campaigns led by government institutions, the UNHCR and IOM that could be adapted to include SGBV messaging. In Tabasco and Chiapas, for example, municipal authorities have implemented an initiative to spread information about local services, including shelters for youth, through the use of brochures, posters, social media, and TV and radio communications. The UNHCR, through its online Jaguar campaign in Guatemala and Mexico, has focused on increasing awareness about the right to seek asylum in Mexico as well as general information regarding services like shelters along the migration route. The IOM has recently launched a "Migrant App" that maps different service providers throughout Mexico; researchers were unable to learn details of the program.

Other strategies

Cultivating community liaisons or representatives was mentioned as an awareness raising technique that would allow migrants and refugees to obtain information from their peers. Providers agreed that trusted peers would appear to be reliable sources of information, particularly given the context of insecurity.

Additional considerations for awareness raising

In addition to the strategies, ideas, and considerations for awareness raising described above, informants raised several additional points to keep in mind while designing outreach and information campaigns. These revolved around: (1) special considerations for people with diverse SOGI, (2) issues of misinformation and the sensitization of other actors, and (3) the need for coordinated, regional efforts.

Special considerations for individuals with diverse SOGI: Organizations supporting LGBTI refugees and migrants face greater obstacles in their awareness raising efforts. In Guatemala in particular, informants mentioned national advertisements and campaigns raising awareness about sexual and gender diversity are expensive, as advertising agencies will double the price due to the "negative effect" exposure to LGBTI individuals supposedly has on children and the public. Key informants stated this prejudice toward LGBTI people also made it risky for them as an organization to provide information on asylum, protection, and migration to LGBTI individuals in Guatemala, especially to those engaged in sex work, as the organization itself could come under fire for supposed promotion of human trafficking.

Misinformation and sensitization of other actors: Key informants raised issues of misinformation, both amongst refugees and migrants and amongst service providers. They mentioned that some refugees and migrants have false information about their rights or the services they can and cannot access, which may be spread over social media or in person at common gathering places such as public parks. Additionally, informants noted that not all service providers in Mexico are aware that migrants and refugees have the right to access services regardless of their legal status. This raised the issue of expanding awareness raising campaigns to include knowledge of service providers themselves on displacement and SGBV. In particular, informants mentioned that it is useless for migrants and refugees to know their right to access healthcare if hospital staff is unaware of this right and denies treatment. They also emphasized the importance of police knowing how and being willing to help refugees and migrants, given police are frequently the first to come into contact with refugees and migrants on the road.

Coordinated, regional efforts: Informants mentioned that awareness raising strategies should span the entire length of the journey (countries of origin, transit countries, destination countries) and involve actors both at home and in the U.S., including Central American communities from which many migrants and refugees originate as well as migrant and refugee communities already living in the U.S. Providers noted, for example, that church groups or migrant and refugee organizations based in the U.S. can be useful networks for information dissemination, and contacts in the U.S. can keep loved ones up to date on the latest information and trusted organizations along the route.

DISCUSSION

Disclosure as a concept

Findings reveal that the concept of disclosure requires more nuanced thinking in order to improve service provider response in different contexts. We propose a 3-pronged typography of SGBV disclosure to illustrate the different reasons it may happen, to whom, and under what conditions. As described further in Appendix A, SGBV disclosure in the service provision context can roughly be categorized as:

- "Self-motivated" disclosure: Survivor has independent reason or intent to disclose SGBV, regardless of environment or provider action.
- "Enabled" disclosure: Survivor feels encouraged to disclose SGBV due to the existence of a supportive environment or general showing of receptivity on the part of a provider.
- "Probed" disclosure: Survivor discloses in response to providers' direct questioning about past traumatic experience, which may include direct or indirect probing about SGBV.

All service providers should be prepared for cases of "self-motivated disclosure," however rare. Even where referral to medical, psychological, or legal support is not possible, providers should be prepared to administer psychological first aid and other minimum forms of care. In addition to being prepared for self-initiated disclosure, service providers should strive to create an environment in which enabled disclosure can occur. This entails creating a safe, welcoming space for all migrants and refugees, regardless of age, gender or other identity, with staff demonstrating receptivity, empathy, and availability.

With regard to "enabling" SGBV disclosure, it is helpful to think in terms of structural and institutional measures, as well as individual, interpersonal measures. Findings indicate that providers already try to create comfortable, safe environments that signal receptivity to SGBV disclosure by setting up a "home-like" shelter or making time for small talk. Should these efforts succeed and a survivor comes forward to disclose SGBV, service providers should be prepared to provide psychological first aid and, where possible, referrals for medical, psychological, or legal support.[44]

Generally, and contrary to the first two types, "probed disclosure" should not occur unless: (1) there is a clear benefit the refugee or migrant seeks (such as building an asylum claim or filing a police report), and (2) adequate support services can be provided. If these two conditions are met, providers should be properly trained to employ both direct and indirect questioning strategies in a sensitive manner when probing for SGBV disclosure. There are additional considerations in a highly mobile context. Without being able to refer an individual to service providers up the road, or without the possibility of arranging follow up during a refugee's or migrant's brief stay at a shelter, it may not be appropriate for service providers to actively pursue disclosure of SGBV. However, this does not preclude the importance of being prepared for cases of self-motivated disclosure and creating an environment that could enable disclosure, and providers should have a minimum package of services available for survivors in need.

Unique aspects of displacement in Central America and Mexico

Three unique aspects of the displacement context in Central America and Mexico emerged as important considerations for SGBV disclosure. First, providers repeatedly stressed that the **highly mobile migration context** made it extremely difficult to build the necessary trust for enabling SGBV disclosure and providing services. Migrants' and refugees' desire to "keep moving" often trumped their willingness

to seek assistance. Moreover, most existing guidelines on SGBV detection and response do not address how to assist survivors who are quickly passing through and are unable or unwilling to wait for an appointment – even if it is scheduled for the next day. Second, informants highlighted the **environment of high insecurity and violence** wherein migrants and refugees are at risk of being found and assaulted by gangs, criminal groups and other ill-intentioned actors. This violent environment makes it difficult and dangerous for migrants and refugees to trust people they encounter along the way, including service providers or fellow shelter residents. Third, the **diversity of displacement profiles** in the region complicates SGBV disclosure even further. A single shelter in Guatemala, for instance, may be serving foreign migrants passing through for a single day, resident refugees from further south in Central America, returnees arriving back in the country, and internally displaced people who just escaped from other regions of Guatemala. Service providers need to be ready to address the differing needs of these groups and tailor referral pathways accordingly so as to ensure equal access to protection.

In the context of **high mobility**, findings suggest that service providers should refrain from actively probing for disclosure unless they are prepared to give an immediate support service or provide a referral that aligns with migrants' and refugees' travel needs. For example, if a woman was raped within the last 72 hours, it would be appropriate for a provider to ask probing questions if he or she can ensure the immediate provision of post-rape care. With regard to referrals, it is commendable that the UNHCR Regional Safe Spaces Network is strengthening SGBV service coordination along the migration route. This should help improve providers' ability to give reliable advice about support options down the road, if a migrant or refugee cannot pause for long at that moment of contact. Where refugees and migrants do stay at shelters for a night or two, SGBV-related information could be provided right up front, perhaps as part of orientation presentations, as is already done in several shelters in the region. For cases in which refugees and migrants are simply moving too quickly to make contact with service providers at all, broad awareness raising campaigns become critical. Outreach strategies must be creative, multi-faceted and far-reaching. Know-your-rights content, especially rights to healthcare (including sexual and reproductive health) and SGBV-related protection, are particularly valuable for refugees and migrants to know, no matter how quickly they are moving or whatever route they take. Knowledge about an SGBV or general assistance hotline would help survivors, their families, and their communities access advice and assistance at multiple points on the journey, whenever they are ready. Given the context of high mobility, a cross-border general assistance hotline and strategy would likely serve survivors most effectively.

High levels of insecurity also complicate SGBV disclosure, serving as a barrier and also creating potential risk once a person has been identified as a survivor of violence. To protect refugees' and migrants' physical safety, providers should not probe for disclosure of SGBV or record personal information unless such probing is justified and the provider has both strong referral and secure data storage and information management systems in place.[45] Ideally, providers would assess a refugee's or migrant's security concerns and, where possible, be prepared to refer survivors to any available services. Finally, creating an enabling environment for SGBV disclosure in an insecure context requires building additional trust with migrants and refugees by re-emphasizing confidentiality of information and reassurances of survivors' safety. Providers can also help individuals identify symbols that indicate safety, such as the Safe Spaces Network logo, logos of humanitarian agencies, religious symbolism, etc.

The **diversity of legal status and national origin** among refugees and migrants further nuances SGBV disclosure and response in this displacement context. When returnees, refugees, asylum seekers, migrants and others on the move are all staying in the same shelter, service providers face different timelines for building the necessary trust for disclosure and must also contend with different types of referral pathways available to survivors based on legal status and movement. However, shelter providers in particular are also uniquely situated to gather collective migrant and refugee experiences, build peer rapport among fellow residents, and widen communication networks useful for SGBV awareness raising. Additionally,

providers can work with longer-term residents who can create rapport and liaise with peers staying only a few days, contributing to a more enabling environment for SGBV disclosure with mobile populations.

Diversity of SGBV experiences and survivor groups

SGBV survivors seen by providers in the North and Central American displacement context are striking in their diversity. Survivors are of every age, gender identity, and sexual orientation, and are diverse in terms of other identities such as ethnic origin and ability. The identities of perpetrators include spouses, family members, smugglers, "travel spouses," police and authorities, traffickers, and members of gangs and criminal groups. Incidents of SGBV occur back home and can be a reason for leaving, and also occur in transit. The types of harm and contexts in which they occur vary according to gender and age, and can include: domestic violence; discrimination and prejudice against women, girls, boys, and LGBTI individuals from varying ethnic or indigenous backgrounds; sex trafficking; transactional sex for "safe" passage or other services; and sexual assault in robbery contexts where perpetrators attempt to humiliate migrants and refugees.

This diversity of SGBV experiences and survivor groups means there can be significant differences in terms of barriers to disclosure and risks to survivors who disclose. This diversity also mandates different techniques to enable or, where appropriate, probe for SGBV disclosure within these different groups. Survivors have different needs in terms of response and treatment options, and providers must adapt and expand their services and referral networks accordingly. Finally, any attempts to raise awareness about SGBV during the displacement cycle will need to further emphasize the importance of considering the diversity of barriers, risks, and needed services or information according to these diverse survivor groups and forms of harm.[46]

Developing a communications and outreach strategy

In a highly mobile migration context where service providers do not have sufficient time to offer extensive care, let alone build the necessary rapport to enable SGBV disclosure, raising awareness with migrants and refugees on the move about available services and their right to seek help is the most feasible means of encouraging them to seek assistance at some point along their journey. Developing a cross-border outreach and communications strategy is thus essential for supporting refugees and migrants on the move. Findings revealed helpful insights regarding the **content** and **form** of outreach materials, **where** and **how** information can be disseminated, **who** should be the target audience, and points of **caution** to take into consideration.

Findings suggest that any SGBV-specific awareness raising strategy needs to include information about refugees' and migrants' rights, services available to them, and where they can access such services. To minimize risk of targeting both forced migrants and service providers, broader public initiatives should avoid revealing specific information about the location of shelters and other services. Instead, public campaigns should focus on providing emergency hotline numbers and sensitizing populations on their rights to seek support for SGBV through medical, psychological, legal, and other specialized services.

This information can be packaged in myriad ways, some of which are already utilized by current outreach campaigns in the region: pamphlets and flyers; murals, billboards, and posters; maps and comic book formats; videos[47] and interactive games; presentations and discussion groups. Findings suggest a preference for visual materials with graphics over materials with large amounts of text, as these are more accessible for a diverse population. Materials can be distributed in shelters, civil society organizations,

hospitals, and public institutions. They can also be posted visibly in key points along the migration route, including border crossings, train stations, bus stops, and public parks. Different creative strategies for disseminating information and materials also emerged from findings. These included sending mobile clinics to border crossings, organizing community workshops on sexual and reproductive health, and having returnees in countries of origin share their experiences on local community radio programming. On the whole, however, informants repeatedly expressed that information provided in person is most effective. Providers should find ways to solicit input from refugees and migrants about the effectiveness of these initiatives.

Messaging on these materials can consider a range of target audiences, including of course migrants and refugees in shelters, asylum seekers, and migrants and refugees on the move who may not otherwise come into contact with service providers. Findings suggest other audiences should be considered as well, however, including residents in countries of origin, host communities, and diaspora communities in the U.S. The diaspora in the U.S. is particularly well situated to communicate with migrants and refugees on the move, and can be a source of updated information for friends and loved ones. Healthcare and law enforcement professionals were also mentioned as potential target audiences, with informants noting the importance of SGBV awareness raising initiatives focused on learning migrants' and refugees' rights in transit countries and improving sensitive response to SGBV survivors.

Reaching such a broad audience requires increased coordination of information campaigns across the region, including communities in home countries, transit countries, and destination countries. SGBV awareness raising can build on existing campaigns, like UNHCR's Jaguar campaign. Interestingly, the utility of social media was inconclusive, suggesting the need for further research and cautioning against over-reliance on social media as a communication method. Moreover, the capacity to track location on social media poses a significant security threat to refugees and migrants that should be carefully considered. Regional insecurity also led providers to caution against the public advertising of specific locations of shelters and services, as this could expose migrants, refugees, and service providers to harm.

Specific considerations for humanitarian actors

Findings highlight the fact that humanitarian actors have a fundamentally different interest and role than that of legal authorities with regards to SGBV disclosure. While lawyers or police may pursue disclosure for the purposes of filing an asylum application or investigating a crime, most service providers in this displacement context serve a humanitarian mandate. As such, they prioritize the well-being of individual migrants and refugees by providing access to shelter and medical, psychological, and social assistance. Maintaining the humanitarian frame of reference when considering options for SGBV disclosure is crucial for shelter staff, medical workers, social workers, and psychologists, as it places the individual's needs before institutional or state priorities.

This distinction in roles has implications for SGBV disclosure. First, many service providers who are not actively pursuing information about a migrant's or refugee's SGBV-related experiences may still be confronted with it; they will need to be able to provide immediate and sensitive response and referral. Second, as first responders, many service providers may face migrants' and refugees' questions about legal rights and processes that are beyond their personal expertise. While onward referral to a specialized lawyer is helpful, it is not always possible. It is therefore imperative that all service providers and their individual staff members have basic and accurate understanding about legal rights and options so they can respond in a limited, but accurate, way if asked — there may not be a chance to go back and revise one's advice. Finally, it is important to build strong and healthy relationships with trusted partners in the relevant state institutions who may be able to provide a survivor more in terms of protection and access to justice.

RECOMMENDATIONS

Based on the above findings, we offer the following recommendations:

SGBV disclosure

1. **Take a multifaceted approach to SGBV disclosure, both as a concept and practical reality.**

SGBV disclosure can happen for many different reasons, in many different ways. Facilitate discussions with staff and partners about their personal and organizational preparedness for SGBV disclosure that may be "self-motivated," as well as ways to "enable" potential SGBV disclosure through the creation of a safe and supportive environment. Finally, determine whether it is appropriate for anyone on staff to "probe" for disclosure: What is the benefit to the survivor? Is inquiring about SGBV an appropriate part of the organization's mandate? If so, clarify who on a team should fulfill this role and whether they are prepared to do so. *See Appendix A for a proposed typography of SGBV disclosure types, scenarios, and considerations.*

2. **Train *all* staff members on SGBV, disclosure, and referral pathways.**

Conduct a full-staff training on SGBV. This should include building sensitivity about SGBV forms and impacts, as well as discussing disclosure considerations and techniques. It is critical to engage the entire staff — even beyond SGBV focal points or counselors — in order to increase a team's overall receptivity and responsiveness to SGBV. Full engagement of shelter staff in particular increases the potential access points a resident may have: everyone from security guards to cooks to administrative staff should be able to signal receptivity to SGBV disclosure and be equipped to handle it. *See Appendix B for a proposed "SGBV Disclosure" staff training module.*

3. **Continue developing context-specific guidance on the creation of safe, enabling environments.**

Each organization must take its own physical space, team culture, and social geographic context into account when approaching SGBV disclosure. Facilitate a brainstorming session with staff, experts, and migrants and refugees themselves to develop context-specific "Do's & Don'ts" for creating a work environment that signals receptivity to discussion of SGBV and the availability of assistance. Guidance should address practical and structural aspects (eg, arranging or decorating an office, providing confidential spaces, ensuring gender-diverse staffing shifts) as well as behavioral and communication tips (eg, learning migrants' and refugees' colloquial expressions for sexual acts, taking casual breaks with residents). *See Appendix C for sample "Do's and Don'ts" and Appendix H for the "Regional Safe Spaces Network Self-Audit Checklist."*

4. **Facilitate group activities to broach SGBV.**

In contexts where migrants and refugees spend considerable time, facilitate group activities to open up awareness and conversation about SGBV and indicate receptivity to SGBV disclosure. SGBV-related issues can be presented in the context of reproductive health workshops, group therapy sessions, "risks of the road" presentations, and other activities. For example, role-playing dramas and "open story"

techniques can stimulate discussion about risk factors, sources of support and protection, and even legal rights. SGBV should be included in all organizations' community-based strategies. *See Appendix F for examples of group activities used to broach issues of SGBV.*

5. **Create consistent opportunities for one-on-one interaction with refugees and migrants.**

Disclosure often depends on rapport. Rapport often depends on familiarity. Safe spaces staff, shelter staff, and other staff in regular contact with migrants and refugees should create routine opportunities for one-on-one discussion and unstructured social time with residents. This could be in the form of regular chores, check-ins, and other informal interactions between migrants, refugees, and staff. State actors should also see every interaction with migrants and refugees as an opportunity to check in about SGBV. For example, if officers at COMAR or INM see certain asylum seekers on a regular basis, they should find ways of inquiring about their well-being. A simple but consistent, "How are you doing?" from an authority figure may slowly help establish rapport and increase some migrants' and refugees' willingness to ask for help.

6. **Establish national or bi-national SGBV hotlines in Mexico and Guatemala.**

To provide a consistent centralized resource for survivors of SGBV in Mexico and Guatemala, including migrants and refugees, establish a telephone hotline for SGBV-related assistance. Ideally, this could be a single bi-national hotline that can immediately connect or refer callers to relevant actors, including those in the Regional Safe Spaces Network, state actors and even civil society organizations, depending on caller location. Alternatively, two national hotline services can be established — one in each country — that should then be coordinated with one another. Stakeholders should explore possible hotline functions, confidentiality protocols, and sustainability models. For example, it may be possible for relevant Mexican and Guatemalan actors to partner with telecommunication providers to secure free calling.

Awareness raising

7. **Consult migrants, refugees, and service providers when developing printed materials about SGBV and the Regional Safe Spaces Network; seek their input regarding dissemination strategies.**

Develop printed materials containing SGBV-related content, including information on the Regional Safe Spaces Network. Create content and dissemination strategies in consultation with migrants, refugees, and service providers, taking into account a displacement context characterized by: a.) diverse identities and abilities, b.) conservative norms regarding gender, SGBV, sexual and reproductive health, c.) rapid and evolving movement, d.) diverse displacement profiles, e.) legal and social insecurity and protection needs, and f.) physical insecurity and protection needs. Content and format exploration may include collecting colloquial terms for sex, addressing gender-specific healthcare needs, or creating comic books. Dissemination strategies may require mapping of how diverse groups of people tend to travel or gather. This can be done through the implementation of the Regional Information Sharing Protocol (RISP) recently developed by the RSSN. Then go to them: Identify actors who are already providing mobile safe spaces and engage them for assistance in disseminating SGBV and RSSN-related materials.

Finally, printed materials should be developed with refugee and migrant security and safety in mind: frame content generally, to avoid creating suspicion that the individual carrier has suffered SGBV or intends to report a crime. *See Appendix E for guidance on developing a strategy for printed materials.*

8. **Make creative use of common areas and public spaces.**

Common areas in shelters, offices, and hospitals, as well as more public spaces where migrants and refugees pass or congregate, can be good places to communicate information about SGBV. Develop and display SGBV-specific posters targeting different migrant and refugee profiles where they are known to gather (eg, women, children, men, LGBTI individuals). Also consider creating SGBV-focused murals or billboards near the roadside, train tracks, or major border crossing points. *See Appendix D for suggestions regarding use of common areas.*

Also: Explore spaces where migrants and refugees gather that would be safe for dramatic activities about SGBV, as discussed above. *See Appendix F for examples of facilitated group activities that can be adapted for outdoor, public spaces*.

9. **Build on what exists: expand general outreach mechanisms to include SGBV.**

Adapt existing communications initiatives to address SGBV, such as UNHCR's videos about the Mexican asylum application process generally. New initiatives, such as UNHCR's Jaguar campaign and IOM's MigrantApp, may be useful vehicles for enhanced messaging about SGBV-related rights and services. Approach local actors engaged in mobile safe spaces, clinics, food and assistance distribution efforts along the train lines as possible allies in the distribution of SGBV-related materials.

10. **Develop a coordinated SGBV outreach campaign across countries of origin, transit, and destination in the region jointly with the Regional Safe Spaces Network.**

Many refugees and migrants plan routes that pass around service provider offices. To raise awareness among these "invisible" migrants and refugees, consider ways in which information disseminated in countries of origin and return, transit countries, and countries of destination can be coordinated for maximum reach, coherence and impact. In countries of origin, despite political sensitivity surrounding outreach about emigration and asylum, it may still be useful to address potential migrants' and refugees' questions about their rights and risks along the road ahead. In transit or interim host countries, know-your-rights materials help migrants and refugees where they stand; these messages should complement and add detail to earlier information received in their home countries. Finally, outreach to destination countries is critical, given the crucial role of diaspora family and community members who await migrants and refugees. These relatives serve as sources of travel information, financing, and arrangement; outreach to them can provide accurate information they can share with loved ones *en route*. Include specific messaging about SGBV-related risks, rights, and resources in this overall communications strategy. Assess for appropriate methods of communication; television, radio, and social media may be more useful venues in home and destination countries than in transit areas.

General

11. **Tailor approaches to diverse refugee and migrant populations.**

The diversity of North and Central America's forcibly displaced populations requires multifaceted approaches to SGBV-related disclosure and outreach. Risk factors, disclosure inhibitors, and support needs may differ based on a survivor's age, gender, or sexual orientation; they may also be complicated by a migrant's or refugee's physical or legal insecurity at any point of his or her journey. Training, materials, service provision, and advocacy should take multiple survivor profiles into account.

12. Find and use the right language.

Sex and violence can be difficult to discuss, even in a common language. When working with refugees and migrants, providers may find that terms may differ based on age, gender, sexual orientation, country of origin, social or ethnic origin, or other characteristics. Providers should maximize the clarity of all their communication about SGBV– in personal conversation as well as in outreach materials. Consult targeted populations about the slang, euphemisms, and common expressions used to describe relevant sexual acts, body parts, etc. Create a list of common terms used by different groups for staff training and outreach materials.

13. Strengthen coordination of SGBV services in Mexico and Guatemala.

There is a great need for consistency and coordination of SGBV case management in Mexico and Guatemala to improve survivors' access to information along the road and continuity of care. Providers should explore ways to establish a multi-country case management system with shared, secure data management and coordinated referral mechanisms. The Regional Safe Spaces Network can be a starting point for building out cross-border coordination.

14. Develop feedback and complaint mechanisms to improve SGBV-related service provision.

Obtaining feedback from migrants and refugees concerning their experience with service provision is key to improving SGBV detection and response, and can help identify new strategies for enabling SGBV disclosure where appropriate. Facilitating migrants' and refugees' ability to voice service-related complaints in a safe and accessible manner is also crucial for ensuring accountability to the communities with whom providers work. Service providers should thus meet to discuss what a feedback and complaint mechanism could look like and how it could best be implemented and coordinated along the migration and service routes. Possible approaches could include check-in or evaluation questions during intake procedures or setting up a telephone line hosted by UNHCR.

15. Prioritize staff well-being.

Service providers working closely with migrants and refugees can be deeply impacted by the work they do and the people they care for, particularly in resource-limited settings where one may feel unable to meet the full need for assistance. Providers can carry significant emotional burden, including those with most direct and consistent contact with survivors of SGBV and other survivors of traumatic experiences. Employers – whether private organizations or state institutions – should prioritize the well-being of their staff and provide self-care trainings, regular check-ins, and internal support measures.

16. Conduct further research.

This exploratory inquiry is only a pilot project. Much more in-depth research is necessary to better understand SGBV disclosure and to develop effective awareness raising campaigns for the Northern and Central American displacement context. Priority questions for further research include: What are migrants' and refugees' priority services regarding exposure to SGBV? What information about SGBV do diverse groups of migrant and refugee populations want? How do migrants and refugees use social media and mobile phones during migration? These data should be collected and disaggregated to identify trends in age, gender, and diversity, including ethnic origin, gender identity and sexual orientation.

ENDNOTES

[1] An Amnesty International report estimates 6 in 10 women are raped on their journey; see Amnesty International, *Invisible Victims: Migrants on the Move in Mexico* (London: Amnesty International Publications, 2010), 15, www.amnestyusa.org/wp-content/uploads/2017/04/amr410142010eng.pdf. Another article cites statistics from migrant shelters along Mexico's southern border, which estimate that 8 in 10 women are raped or experience some other form of sexual violence; see Alyson L. Dimmitt Gnam, "Mexico's Missed Opportunities to Protect Irregular Women Transmigrants: Applying a Gender Lens to Migration Law Reform*," Pacific Rim Law & Policy Journal Association* 2013: 722. Lower numbers were cited in a study conducted by Mexico's National Institute of Public Health, where out of 750 migrants interviewed at a shelter in Tapachula, 8.3% of surveyed women reported forced sexual intercourse during their journey and 28.2% reported exchanging sexual relations for goods or services; see César Infante, Flor María Rigoni, Jorge Velázquez, Ubaldo Ramos, and René Leyva, "Migrantes en tránsito por México: Derechos sexuales y reproductivos," in René Leyva Flores and Frida Quintino Pérez, eds., *Migración y Salud Sexual y Reproductive en la Frontera Sur de México* (Cuernavaca: Instituto Nacional de Salud Pública, 2011), 100, table 5.5. Lastly, other researchers cite an estimate that 24% of women experience some form of sexual violence during migration, along with 5% of men and 50% of LGBTI individuals; see Gabriela Díaz Prieto and Gretchen Kuhner, *Un Viaje Sin Rastros: Mujeres migrantes que transitan por México en situación irregular* (Mexico City: H. Cámara de Diputados, LXII Legislatura; Consejo Editoria, Instituto para las Mujeres en la Migración A.C., 4ta.; Editores S.A. de C.V., 2014), 85-86.

[2] See for example: Andrea Wirtz, Nancy Glass Kiemanh Pham, Amsale Aberra, Leonard S. Rubenstein, Sonal Singh and Alexander Vu, "Development of a screening tool to identify female survivors of gender-based violence in a humanitarian setting: qualitative evidence from research among refugees in Ethiopia," *Conflict and Health* 7, no. 13 (2013): 1-14; Ramin Asgary, Eleanor Emery and Marcia Wong, "Systematic review of prevention and management strategies for the consequences of gender-based violence in refugee settings," *International Health* 5, no. 2 (2013): 85-91; Zahra Mirghani, Joanina Karugaba, Nicholas Martin-Achard, Chi-Chi Undie and Harriet Birungi, *Community Engagement in SGBV Prevention and Response: A Compendium of Interventions in the East & Horn of Africa and the Great Lakes Region* (Nairobi, Kenya: Population Council, 2017).

[3] For discussion of sexual assault disclosure, see: Dr. Catherine Esposito, "Child Sexual Abuse and Disclosure: What does the research tell us?", New South Wales Government: Family & Community Services, 2014, http://www.community.nsw.gov.au/__data/assets/pdf_file/0020/321644/Literature_Review_How_Children_Disclose_Sexual_Abuse.pdf; Caitlin L. McLean, Marisa K. Crowder and Markus Kemmelmeier, "To honor and obey: Perceptions and disclosure of sexual assault among honor ideology women," *Aggressive Behavior* (2018): 1-20.

[4] For discussion of HIV status disclosure, see: Carla Makhlouf Obermeyer, Parijat Baijal, and Elisabetta Pegurri, "Facilitating HIV Disclosure Across Diverse Settings: A Review," *American Journal of Public Health* 101, no. 6 (2011): 1011-1023.

[5] For discussion of sexual orientation disclosure, see: Kristin H Griffith and Michelle R Hebl, "The disclosure dilemma for gay men and lesbians: "Coming out" at work," *Journal of Applied Psychology* 87, no. 6 (2002): 1191-1199.

[6] For discussion of disclosure processes and contexts, see: Sharon G. Smith, "The Process and Meaning of Sexual Assault Disclosure," PhD dissertation, Georgia State University, 2005, http://scholarworks.gsu.edu/psych_diss/7; Sarah E. Ullman and Henrietta H. Filipas, "Correlates of formal and informal support seeking in sexual assault victims," *Journal of Interpersonal Violence* 16, no. 10 (2001): 1028-1047.

[7] For more information on women fleeing SGBV, see: United Nations High Commissioner for Refugees (UNHCR), *Women on the Run: First-Hand Accounts of Refugees Fleeing El Salvador, Guatemala, Honduras, and Mexico* (Washington, D.C.: UNHCR, 2015), http://www.unhcr.org/publications/operations/5630f24c6/women-run.html.

[8] For helpful guidance on understanding the broader context and protection needs of displaced people from Central America's Northern Triangle (El Salvador, Guatemala, Honduras), see:

—UNHCR, *Eligibility Guidelines for Assessing the International Protection Needs of Asylum-Seekers from El Salvador*, HCR/EG/SLV/16/01, March 2016, http://www.refworld.org/docid/56e706e94.html;

—UNHCR, *Eligibility Guidelines for Assessing the International Protection Needs of Asylum-Seekers from Guatemala*, HCR/EG/GTM/18/01, January 2018, http://www.refworld.org/docid/5a5e03e96.html;

—UNHCR, *Eligibility Guidelines for Assessing the International Protection Needs of Asylum-Seekers from Honduras*, HCR/EG/HND/16/03, July 2016, http://www.refworld.org/docid/579767434.html.

[9] See Appendix G; see also Médecins San Frontières, *Providing Antiretroviral Therapy for Mobile Populations: Lessons Learnt from a Cross Border ARV Programme in Musina, South Africa, Cape Town*, July 2012,

http://www.msfaccess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_report_ARTformobilepops_ENG_2012.pdf; Matthew Price et al., "mHealth: A Mechanism to Deliver More Accessible, More Effective Mental Health Care," *Clinical Psychology & Psychotherapy* 21, no. 5 (2014): 8; and K. Y. Leung and W. S. Leung, "Empowering Refugees and Migrants in South Africa through ICT4D," in *2016 IST-Africa Week Conference*, 2016, 1–9.

[10] See Appendix G; see also UNHCR Innovation Service, "Increasing Two-Way Communication with Refugees on the Move in Europe," 2017, http://www.unhcr.org/innovation/increasing-two-way-communication-with-refugees-on-the-move-in-europe.

[11] In this report, "refugee" is used when referring to forcibly displaced individuals who meet the definition set out in the 1951 Convention Relating to the Status of Refugees and its 1967 Protocol, in which a refugee is someone who, "owing to 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 his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country." Additionally, the 1985 Cartagena Declaration includes "persons who have fled their country because their lives, safety or freedom have been threatened by generalized violence, foreign aggression, internal conflicts, massive violation of human rights or other circumstances which have seriously disturbed public order" to the definition of "refugee" in the Americas. Since most actors in the region work both with refugees and migrants and since many findings and recommendations are relevant for both groups, the report refers to "migrants and refugees" to include all individuals on the move through Central America and Mexico.

[12] UNHCR, "Mexico: Factsheet," February 2017, http://reporting.unhcr.org/sites/default/files/Mexico%20Fact%20Sheet%20-%20Februrary%202017.pdf.

[13] International Crisis Group, *Easy Prey: Criminal Violence And Central American Migration,* Latin America Report N°57, July 28, 2016, 3, https://www.crisisgroup.org/latin-america-caribbean/central-america/easy-prey-criminal-violence-and-central-american-migration.

[14] UNHCR, "Global Focus: Mexico," 2016, http://reporting.unhcr.org/node/2536.

[15] Comisión Mexicana de Ayuda a Refugiados, "Estadísticas," 2013-2017, https://www.gob.mx/cms/uploads/attachment/file/290340/ESTADISTICAS_2013_A_4TO_TRIMESTRE_2017.pdf.

[16] Inter-American Commission on Human Rights and the Organization of American States, *Human Rights of Migrants and Other Persons in the Context of Human Mobility in Mexico*, OEA/Ser.L/V/II, Doc. 48/13, December 30, 2013, 90-92, http://www.oas.org/en/iachr/migrants/docs/pdf/Report-Migrants-Mexico-2013.pdf.

[17] Amnesty International, *Invisible Victims,* 22.

[18] Dimmitt Gnam, "Mexico's Missed Opportunities to Protect Irregular Women Transmigrants," 722.

[19] Prieto and Kuhner, *Un Viaje Sin Rastros*, 85-86.

[20] Ibid., 69.

[21] Ibid., 64–69; Gabriela E. Sanchez, "Latin America," in *Migrant Smuggling Data and Research: A Global Review of the Emerging Evidence Base*, New York: UN, 2016.

[22] Wendy Vogt, "Stuck in the Middle with You: The Intimate Labours of Mobility and Smuggling along Mexico's Migrant Route," *Geopolitics* 21, no. 2 (2016): 378.

[23] Alberto Nájar, "Qué Es La 'Inyección Anti-México' Que Toman Las Migrantes Centroamericanas," *BBC Mundo,* October 19, 2015, www.bbc.com/mundo/noticias/2015/10/151019_inyeccion_anti_mexico_migracion_centroamerica_mexico_an.

[24] César Infante, Rubén Silván, Marta Caballero and Lourdes Campero, "Sexualidad del migrante: experiencias y derechos sexuales de centroamericanos en tránsito a los Estados Unidos," *Salud Pública de México* 55, no. 1 (2013): s62-s63.

[25] Médecins Sans Frontières, *Forced To Flee Central America's Northern Triangle: A Neglected Humanitarian Crisis*, May 2017, 19, www.msf.org/sites/msf.org/files/msf_forced-to-flee-central-americas-northern-triangle_e.pdf.

[26] UNHCR, "Red Regional de Espacios Seguros: México" (presentation, 2017).

[27] UNHCR, "Red Regional de Espacios Seguros: México" (presentation, 2017); UNHCR, "Red Nacional de Espacios Seguros" (presentation, UNHCR Country Office, Guatemala City, November 13, 2017).

[28] For an index of fieldwork interviews conducted, see Appendix I.

[29] For discussion of SGBV disclosure barriers for displaced populations, see: Andrea Wirtz, Nancy Glass, Kiemanh Pham, Amsale Aberra, Leonard Rubenstein, Sonal Singh and Alexander Vu, "Development of a screening tool to identify female survivors of gender-based violence in a humanitarian setting: qualitative evidence from research among refugees in Ethiopia," *Conflict and Health* 7, no. 13 (2013), 1-14; Andrea Wirtz, Kiemanh Pham, Nancy Glass, Saskia Loochkartt, Teemar Kidane, Decssy Cuspoca, Leonard Rubenstein, Sonal Singh and Alexander Vu, "Gender-based violence in conflict and displacement: qualitative findings from displaced women in Colombia," *Conflict and Health* 8, no. 10 (2014), 8-12.

[30] For further insight on the phenomenon of women discussing sexual violence suffered by others but refraining from discussing their own experiences, see: Gretchen Kuhner, "La violencia contra las mujeres migrantes en tránsito por México," *Revista de Derechos Humanos Dfensor,* June 2011, 20, corteidh.or.cr/tablas/r26820.pdf.

[31] In this report, the acronym "LGBTI" is used in keeping with UNHCR's terminology choice. LGBTI and the term "sexual orientation and gender identity," or SOGI, are interchangeable and refer to all sexual and gender non-conforming persons (eg, lesbian, gay, bisexual, transgender, intersex). See: UNHCR, *Protecting Persons with Diverse Sexual Orientations and Gender Identities: A Global Report on UNHCR's Efforts to Protect Lesbian, Gay, Bisexual, Transgender, and Intersex Asylum-Seekers and Refugees*, 2015, 2, http://www.refworld.org/docid/566140454.html.
[32] Women's prioritization of the journey north over seeking access to health services for SGBV is further discussed in Prieto and Kuhner, *Un Viaje Sin Rastros*, 88.
[33] Barriers to disclosure that include fear of the direct consequences of disclosure and reporting are discussed in Kuhner, "La violencia contra las mujeres migrantes en tránsito por México," 21.
[34] For a brief discussion of barriers migrants face to seeking SGBV health services and disclosing to medical professionals in Mexico, see Médecins Sans Frontières, *Forced To Flee Central America's Northern Triangle*, 19.
[35] For in-depth discussion about diverse "shelter" options for refugees fleeing SGBV in camp and urban settings, and when some may be more suitable than others, please see HRC's "Safe Haven" study: Kim Thuy Seelinger and Julie Freccero, *Safe Haven: Sheltering Displaced Persons from Sexual and Gender-Based Violence. Comparative Report*, Human Rights Center, University of California, Berkeley, in conjunction with the UN High Commissioner for Refugees, Geneva (2013), https://www.law.berkeley.edu/files/HRC/SS_Comparative_web.pdf. Additional country-specific case study reports are available at: https://www.law.berkeley.edu/research/human-rights-center/programs/sexual-violence-program/strengthening-protection.
[36] Detection refers to the process of service providers identifying an instance of SGBV as a result of reading certain signals or cues, or as a result of actively questioning a potential survivor. Disclosure refers to the act of a survivor revealing an instance of SGBV, which does not necessarily have to occur in response to direct questioning from a provider.
[37] The Regional Safe Spaces Network has developed a self-audit checklist to assist service providers with creating safe environments for SGBV survivors. See Appendix H.
[38] For helpful guidance on building an organizational strategy involving all staff members to prevent and respond to SGBV, see: UNHCR, *Action against Sexual and Gender-Based Violence: An Updated Strategy*, Division of International Protection (UNHCR: Geneva, 2011).
[39] For resources on SGBV training, see UNHCR's SGBV Prevention and Response Training Package from 2016 at: http://www.unhcr.org/583577ed4.pdf; UNHCR's SGBV e-learning program, https://unhcr.csod.com/client/unhcr/default.aspx.
[40] For information on UNHCR's strategy for responding to sexual violence against children in general, see: UNHCR, "Child Protection Issue Brief: Sexual Violence Against Children," *Child Protection Unit, Division of International Protection* (UNHCR: Geneva, 2014), http://www.refworld.org/docid/52e7c67a4.html.
[41] For helpful guidance on participatory and community-based approaches that can be applied to outreach and awareness raising initiatives, see: UNHCR, *A Community-Based Approach in UNHCR Operations*, 2008, http://www.refworld.org/docid/47da54722.html.
[42] For an example of trainings for border patrol and police on communicating with asylum seekers and identifying protection needs, see: UNHCR, "Ethics and Communication at Border Points," in *UNHCR Protection Training Manual for European Border and Entry Officials* (UNHCR Bureau for Europe: Brussels, 2011), http://www.unhcr.org/4d9474fc9.pdf.
[43] For a discussion of the opportunities and risks of mobile phone use along the U.S.-Mexico border, see: Bryce Clayton Newell, Ricardo Gomez, and Verónica E. Guajardo, "Information Seeking, Technology Use, and Vulnerability among Migrants at the United States–Mexico Border," *Information Society* 32, no. 3, 2016.
[44] The Regional Safe Spaces Network Self-Audit Check-list includes these and other strategies to enable disclosure and provide timely response services; please see Appendix H.
[45] With the support of UNHCR's Regional Legal Unit (SGBV/CP), the Regional Safe Spaces Network is developing a Regional Information Sharing Protocol to ensure safe and confidential collection and analysis of SGBV and Child Protection data. For more information on UNHCR's commitment to and guidance on the safe collection, management, and sharing of information related to child protection and SGBV, see: UNHCR, *Technical Note on UNHCR's Engagement in the Implementation of the Protection Mechanisms Established by Security Council Resolutions 1612 and 1960 (MRM and MARA)*, January 2018, http://www.refworld.org/docid/5a6edf734.html.
[46] For helpful guidance on working with individuals of diverse profiles affected by displacement, including for SGBV response programming, see: UNHCR, *Policy on Age, Gender, and Diversity*, 2018, http://www.unhcr.org/protection/women/5aa13c0c7/policy-age-gender-diversity-accountability-2018.html.
[47] For an example of a UNHCR informational video on asylum in Mexico, see: ACNUR, "Solicitar asilo en México," April 4, 2016, https://www.youtube.com/watch?v=RbWmA-6a8M4.

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APPENDICES

APPENDIX A | SGBV Disclosure: A Proposed Typography

TYPE OF DISCLOSURE		SAMPLE SCENARIOS	COMMONLY IMPLICATED SERVICE PROVIDERS	APPROACHES AND CONSIDERATIONS
SELF-MOTIVATED DISCLOSURE	Survivor has independent reason or intent to disclose SGBV, regardless of environment or provider action.	Survivor wants a pregnancy test at a medical clinic after rape experience. Survivor requests referral to a safe house due to experience or fear of SGBV.	Healthcare providers (medical, psychosocial support) Law enforcement officers Shelter staff *Note: <u>All</u> providers should be prepared for self-initiated disclosure of SGBV, however rare it may be.*	• Capacity to provide psychological first aid. • SGBV sensitization of entire staff, including survivor-centered and rights-based approaches. • Confidential interview space. • Confidential and updated referral, information management, and case management systems. • Diversity of gender, ethnicity, age, language, and sexual orientation / identity on staff, to extent possible.
ENABLED DISCLOSURE	Survivor is encouraged to disclose SGBV due to the existence of a supportive environment or general showing of receptivity on the part of a provider.	Survivor who feels welcome at migrant shelter confides in kitchen staff. Survivor engaged in general group therapy activities eventually feels comfortable revealing individual SGBV experience.	Healthcare providers (medical, psychosocial support) Law enforcement officers Shelter staff *Note: <u>All</u> providers should aim to create a safe, enabling environment for those wishing to discuss SGBV experiences or concerns.*	*All of the "self-motivated disclosure" approaches, plus:* • Creation of safe, welcoming facility. • Engagement of migrants and refugees in routine activities, chores, etc. to create rapport and predictable opportunities to speak freely. • Provision of diverse interaction opportunities, including group activities (know-your-rights trainings, group therapy sessions, etc.) • Display of posters and other materials about SGBV and available support services. • Availability of "SGBV officer," "women's officer," etc.
PROBED DISCLOSURE	Survivor discloses in response to providers' direct questioning about past traumatic experience, which may include direct or indirect probing about SGBV.	Survivor responds to UNHCR staff or lawyer's question about harms fled in home country, asked to determine asylum eligibility. Police are contacted about a crime of SGBV and must question survivor, witnesses.	Healthcare providers (medical, psychosocial support) Law enforcement officers Legal aid attorneys Refugee status determination actors *Note: Most providers should refrain from direct questioning about SGBV unless there is a clear need or benefit to the survivor and provider staff are sufficiently trained.*	*All of the "self-motivated disclosure" approaches, plus:* • Creation of safe, welcoming facility. • Ongoing interview training and skills-development re: SGBV and working with survivors of trauma. • Engagement of, or ready access to, expert on SGBV, gender, vulnerable groups, etc. • Prepared explanation as to why certain questions will be asked, and with what assurances of confidentiality. • Clear intake and documentation procedures. • Safe and confidential information management systems. • Access to trained interpreters.

Sexual Violence Program, Human Rights Center, University of California, Berkeley. January, 2018.

APPENDIX B | SGBV Disclosure: Sample Training Module

As part of a full staff training on SGBV, trainers should specifically address disclosure considerations and techniques. With reception centers and shelters especially, everyone from security guards to cooks to administrative staff should be able to signal receptivity to SGBV disclosure and be equipped to respond sensitively.

Researchers recommend designing a training module that uses role play, scenario analysis in small group discussions, or worksheets depicting disclosure scenarios in comic form. The purpose of these activities is to generate a discussion on how staff can create an enabling environment for SGBV disclosure, without necessarily probing for disclosure via direct questioning. After discussion, training participants jointly generate a list of Do's and Don'ts for enabling disclosure, to serve as the basis for a common framework on creating an enabling environment for disclosure within the organization. A sample list of Do's and Don'ts is included in *Appendix C* of this report.

The following scenario will serve as an example for use and development in the three different proposed activities for full staff training on enabling SGBV disclosure: (1) full group role play, (2) small group discussion, and (3) individual visual worksheet.

Sample Scenario:

A young Mam Mayan woman from the Guatemalan highlands arrives at a shelter just over the border with Mexico with her two children. At the gate, the security guard ushers her in and asks her to sign in on a form. A volunteer approaches her to inform her there will be a group shelter orientation session at 4pm (5 hours from now), and asks her to wait in the intake room for now so that a staff member can talk to her. In the intake room with her children, the woman notices posters on the wall with pictures of people running and looking scared, but she is illiterate and cannot read the captions. She also notices pamphlets with images of children on the table. After twenty minutes of waiting in the intake room, a male staff member enters.

Option 1: Full group role play

In this option, the trainer facilitates a full group role play based on the background scenario presented above. Participants will act out the next scene (intake scene with male staff member) as they think it should be done to best create a supportive, enabling environment that could facilitate SGBV disclosure.

Instructions:

1. Facilitator passes out the written scenario to every participant.
2. Once read, facilitator explains how the role play will work. Four people will act out the scene. Observers then call out "freeze" when they want to pause the scene and someone else wants to jump in to replace one of participants. Scene continues for 10-15 minutes.
3. Facilitator starts by playing the young woman, and asks for volunteers to play the male staff member and the woman's two children.
4. Act out an intake scene, with participants switching in and out as they choose.
5. Once scene is finished, facilitator leads large group discussion. Questions posed can include:
    a. What did the staff member do or say that contributed to creating an enabling environment?
    b. What could the staff member have done differently to create a more enabling environment?
    c. Based on the scenario background, what could other shelter staff have done differently? What steps could the organization itself take to create a more enabling environment?

Option 2: Small group discussion

In this option, the facilitator passes out a piece of paper with the original scenario on it plus the continuation of the intake scene, as described below. Participants read the longer scenario and then break up into groups of 2-3 to answer questions.

Scenario, continued:

The staff member asks the young woman if she is comfortable in the room. She nods, and he sits down across from her. The staff member introduces himself, quickly explains to the woman the rules of the shelter and tells her that he needs to ask her a few questions for the purposes of ensuring her own and other residents' safety. She nods again, but the staff member senses she did not fully understand him. He asks her which language she is most comfortable speaking, listing options based on languages spoken by other staff members at the shelter. She nods when he offers Mam, and states she is from Huehuetenango. The staff member smiles, gets up and says he will be right back. He returns 10 minutes later with a female staff member who greets the young woman and her children in Mam when she enters the room.

Sample discussion questions:

1. What elements of the story **contributed** to creating an enabling environment for SGBV disclosure?
2. What elements of the story **detracted** from creating an enabling environment for SGBV disclosure?
3. What steps could the personnel involved in the scenario take on an **individual level** to create a more enabling environment for SGBV disclosure? What steps could the organization take on an **operational level** to create a more enabling environment for SGBV disclosure?

Sample responses:

*1. Elements that **contributed** to creating an enabling environment (non-exhaustive):*	*2. Elements that **detracted** from creating an enabling environment (non-exhaustive):*
• Volunteer present to direct woman to intake room and inform her of later welcome session. • Existence of a separate, private space to talk one on one. • Staff (guard, volunteer) present at the shelter to usher her in and inform her of what to expect. • Informational material on displacement and different population groups (eg, girls, boys) present in the intake room. • Male staff member asks her if she is comfortable. • Male staff member attuned to young woman's reactions and senses when she doesn't understand. • Male staff member offers to conduct intake in another language in which she is more comfortable. • Presence of diverse staff at shelter, with personnel that speaks other languages common amongst refugees and migrants. • Staff of different genders present at shelter (male, female). • Female staff greets both the woman and her children in her native language when she enters the room before doing or saying anything else.	• Security guard did not greet woman and her children when they arrived. • Residents needing to sign themselves in at the entrance doesn't account for possibility of illiteracy. • Volunteer who approached woman and her children did not greet her or ask if they needed anything right away, such as water, food, rest. • Long wait in the intake room with no explanation of what to expect. • Text-heavy materials not helpful in cases of low literacy. • Male staff member did not greet children or ask if they needed anything before launching in to explanation. • Male staff member explained rules of the shelter before asking her how she was, what she needed, etc. • Male staff member did not ask if woman wanted to speak with or without her children in the room, as she may not feel comfortable talking about violence with them present. • Staff member did not ask for woman's consent to speak to her and ask questions right in that moment and did not offer an alternate time for speaking if she first needed rest. • Male staff member did not inform her that he was going to find another staff member to bring back to the intake room. • Male staff member did not ask her if she preferred speaking with a female or male staff member.

Option 3: Individual visual worksheet

In this option, each participant is given a sheet of paper with the pieces of the longer scenario described above drawn out, as in a comic book. After looking at the images, each participant writes the following on the worksheet:

1. Write a check mark next to or on top of the elements of the scene that help enable SGBV disclosure.
2. Write an "X" over elements of the scene that may discourage SGBV disclosure.
3. Draw in any other physical objects or write in any brief lines of dialogue that could help create a more enabling environment for SGBV disclosure.

Once completed, the facilitator leads a large group discussion where participants share their thoughts on the scene and how they marked it up. Possible discussion questions include:

1. What did you put a check mark next to in the scene? Why?
2. What did you cross out? Why?
3. What did you add? Why?

Suggested images that could be drawn in each panel are described below.

Panel 1:
Woman arrives at a shelter gate with two children. Security guard is opening the gate and ushering her in, looking towards a small booth at the entrance with a sign-in sheet. Speech bubble above guard says, "Please sign in."

Panel 2:
Woman standing at sign-in booth with children behind her. She is holding a pen, hovering over the paper, but is looking anxiously over her shoulder.

Panel 3:
Woman standing on the other side of the entrance gate, after signing in. Volunteer is walking up to her. Speech bubble above volunteer says, "Please wait in the intake room. We will have a welcome session later today at 4pm."

Panel 4:
Woman sitting in intake room with her two children, alone, and looking up at the clock on the wall. There are posters on the walls as well, one with an image of someone running away looking scared, and lots of text around it. A brochure on the table depicts a child and similarly has a lot of text. The woman's children are sitting in the corner on the floor, looking anxious but also a little bored.

Panel 5:
A male staff member is sitting across from the young woman at the table and smiling. The door to the intake room is left open. Speech bubble above his head says, "Hi, my name is Juan, it is nice to meet you. Are you comfortable sitting here?"

APPENDIX C | "Enabled Disclosure" of SGBV: Sample Do's and Don'ts

Do's for individual staff members

- Offer help with basic needs before asking questions about reasons for leaving, experiences of violence in transit, etc.
- Show empathy and compassion.
- Emphasize and demonstrate confidentiality.
- Practice active listening, including making eye contact, being attentive when the person is speaking, ensuring you are not distracted.
- Show that you believe their story.
- Be honest, transparent, and patient.
- Build self-esteem by affirming a person's feelings, desires and expressions.
- Learn refugees' and migrants' colloquial or euphemistic expressions for sexual acts.
- Check in spontaneously to see how someone is doing; pay attention to details and demonstrate care in small ways (eg, giving new shoelaces or playing with children).
- Play games with children and sit on the floor with them to be at the same physical level.

Don'ts for individual staff members

- Never ask someone about violence in the presence of a partner, family member or friend.
- Don't judge or blame an individual for anything that happened to them. Remember that your own life experiences and background may influence how you view or interpret someone else's experiences and behavior.
- Don't criticize an individual if they admit later to having lied about their story previously.
- Avoid body language such as crossing your arms or facial expressions that convey disbelief or irritation.
- Don't push someone to talk if they are uncomfortable or not ready to do so. Instead reassure them that they can talk to you later or refer them to someone else who can help.
- Don't speak openly with colleagues in visible settings about a case or whisper with a colleague right after an individual shares sensitive information with you. This can erode trust and create anxiety.

Do's for organizations and institutions

- Create an inviting facility that is clean, well-lit, and comfortable. For shelters, it may help to replicate aspects of "home" as much as possible, with resident access to a kitchen or garden, or rooms for reading or watching TV.
- Ensure there are confidential spaces for one-on-one talks.
- Display posters and other materials about SGBV and support services.
- Train all staff on psychological first aid and SGBV detection and response.
- Ensure greatest possible diversity of gender, ethnicity, age, language, and sexual orientation / identity on staff.
- Have dormitories for LGBTI individuals and women who solicit this option.
- Engage refugees and migrants in routine activities, chores, etc., to create rapport and provide more opportunities for speaking freely.
- Ensure that shelter or reception staff are visibly accessible to residents for formal and informal conversation.
- Provide diverse staff-resident interaction opportunities, including group activities (know your rights trainings, group therapy, etc.).
- Establish peer support groups amongst refugees and migrants.
- Discuss SGBV in info sessions, stressing that it is never ok and help is available.
- Assign one person to a case (eg, one case worker always sees the same individual) and ensure each case worker or manager has no more than 25 cases at a time.
- Maintain safe, confidential, and updated inter-agency referral and case management systems.
- Ensure access to religious and spiritual counsel if desired.
- Provide for self-care check-ins, trainings, and support of your staff.
- Establish feedback and community-based complaint mechanisms accessible to all population groups, including women, girls, boys, men from diverse backgrounds.

Don'ts for organizations and institutions

- Don't assume your facility feels safe or welcoming: ask for client feedback and ideas about how to create a more comfortable environment.
- Don't expect one SGBV training to be enough. Provide ongoing sensitization and skills-building to improve your team's quality of support and knowledge.
- Don't tolerate discriminatory or stigmatizing comments toward persons or staff in your care. Establish an organizational procedure to confront offending individuals.
- Don't perpetuate isolation, discrimination, or stigmatization of marginalized and diverse groups (eg, indigenous, LGBTI individuals) in shelters, reception centers, during social activities or discussions; be inclusive, sensitive, and compassionate.
- Don't allow staff or the organization to share or use any information a survivor has revealed without first asking permission from the survivor and explaining the purpose of sharing.

Sexual Violence Program, Human Rights Center, University of California, Berkeley. January, 2018.

APPENDIX D | Creative Use of Common Areas

Common areas - both on service provider property and in external, public spaces - can be effective canvases for raising awareness about SGBV. Field research revealed several ways common areas were already used to communicate information about migration or the asylum process. For example, researchers noted the following:

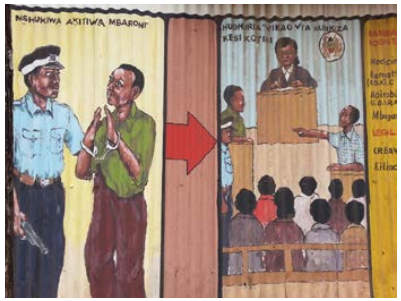
UNHCR Poster

Mural at La 72 Shelter, Tenosique, MX
All photos taken by Kim Thuy Seelinger

Casa del Caminante J'tatic Samuel Ruiz, Palenque, MX

In addition to creating SGBV-specific posters, researchers propose expanding the use of murals in this displacement context to include SGBV messaging.

One interesting example of SGBV awareness raising comes from Kenya, where the Centre for Rights Education and Awareness (CREAW) installed educational murals throughout the slum area of Kibera, Nairobi. Scattered throughout the neighborhood, these murals each depicted different SGBV-related scenarios (different forms of harm, different victim groups). The final panel on each mural indicated where survivors could obtain support services or seek police assistance, including phone numbers. This awareness raising approach was colorful, easy to understand, and highly visible to all members of the Kibera community.



CREAW SGBV murals in Kibera, Nairobi, Kenya. Photo taken by Kim Thuy Seelinger.

These murals could be adapted for the Central American displacement context, if appropriate locations and willing artists can be identified. Diverse groups of people and scenarios could be addressed in different murals. Researchers quickly produced one rough and basic idea to start with, below.

Designed by Kat Madrigal

APPENDIX E | Developing a Strategy for Printed Materials

Dissemination of printed materials is critical in terms of awareness raising — especially since it can be a way of reaching refugees and migrants who are in rapid transit or who prefer not to pass through service provider offices on their journey. This may especially be the case for women, girls, and people with diverse sexual orientation and gender identity who are more exposed to SGBV.

Providers along the Guatemala-Mexico border already use a variety of printed materials to disseminate information about refugees' and migrants' legal rights, available services, and the road ahead. These often take the form of pamphlets, strips of paper, or even mini newspapers. Content varies: for example, they may contain general information about asylum, immigration, and healthcare rights in Mexico or they may simply introduce shelters along the route. Researchers heard few examples of printed material specifically mentioning SGBV or the availability of relevant services.

As noted in the report recommendations, providers should develop SGBV-specific printed materials. To improve the reach and impact of these materials, they should consider ways to reach a displaced population specifically characterized by: a.) diverse identities and abilities, b.) conservative norms regarding gender, SGBV, sexual and reproductive health, c.) rapid and evolving movement, d.) diverse displacement profiles, e.) legal and social insecurity and protection needs, and f.) physical insecurity and protection needs.

Developing and distributing printed materials about SGBV

Local providers are best-placed to develop context-specific strategies for printed materials about SGBV. Below, we propose a simple framework for facilitating a discussion about both content and method of dissemination in light of the specific migrant and refugee populations served.

Migrant and refugee perspectives

In preparing to think through content of SGBV-specific printed materials, it is important to take migrants' and refugees' perspectives into account. For example, focus group discussions could be facilitated with migrants and refugees (current or even former) to identify their most urgent needs and concerns about SGBV. Part of such a discussion could inform the development and dissemination of printed materials. What information would they want or have wanted in printed materials? What formats are most useful? What are the safest and most effective ways to distribute this information? This discussion should be conducted with diverse population groups — eg, older women, younger women, men, boys, girls, and LGBTI individuals, all from diverse backgrounds. The following table proposes a framework for discussion.

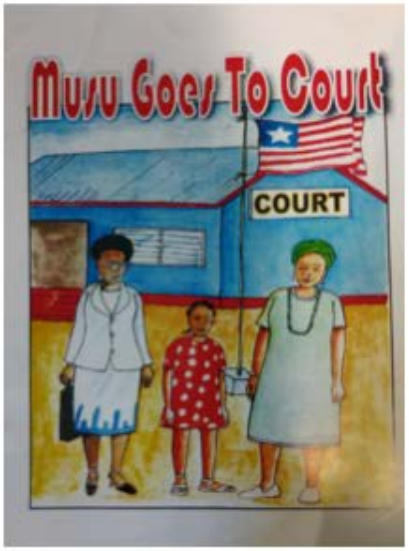
Refugee / Migrant Group	SGBV-related information needs	Concerns and suggestions re: content, format, distribution
CHILDREN: GIRLS, BOYS (under age 15)		
YOUTH: WOMEN, MEN (age 15-29)		
ADULTS: WOMEN, MEN (age 30-55)		
OLDER PEOPLE: WOMEN, MEN (age 55+)		
LGBTI INDIVIDUALS (for each age category, address gay men, lesbians, trans individuals separately)		
OTHER?		

Provider brainstorm about content

Ideally building off of migrants' and refugees' perspectives, local providers are well-positioned to strategize about content of SGBV-related materials. We propose facilitating a provider brainstorming session about ways to tailor content of SGBV-related printed materials to target populations. In preparation, it could be helpful to assemble examples of existing materials in advance, so they can be reviewed and evaluated as a group.

The table below provides a sample framework for subsequent provider discussion:

Population, context considerations *(suggested only)*	**Possible approaches to content** *(suggested only)*	**Existing materials** *(providers to evaluate)*	**New ideas for SGBV materials** *(providers to identify)*
DIVERSE IDENTITIES & ABILITIES	• Identify and use local terms used by different population groups for sex, body parts, violence (i.e. according to diversity in ages, languages, and cultural references) • Use graphic forms (cartoons, maps, other illustrations) • Offer easy-to-memorize information	How do our current printed materials take diverse identities and abilities into account, including differences in language and literacy?	What SGBV-related content would be appropriate given migrants' and refugees' diverse identities and abilities? Consider age, gender identity, sexual orientation, social & ethnic origin, languages, education levels, family composition, abilities and impairments, etc.
CONSERVATIVE NORMS RE: GENDER, SGBV, SEXUAL & REPRODUCTIVE HEALTH	• Identify and use local terms used by different population groups for sex, body parts, violence • Frame SGBV in terms of health and well-being • Note that SGBV can take many forms and is never right; it happens to men, women, children; it can hurt our bodies and hearts • Note that whatever happens to someone, they have the right to get help • Include LGBTI-specific services alongside other service provision lists; use safe language advised by LGBTI advocates	How do our current printed materials take refugees' and migrants' social norms into account?	What SGBV-related content would be appropriate given migrants' and refugees' norms around gender, SGBV, sexual and reproductive health?
RAPID & EVOLVING MOVEMENT	• Introduce SGBV generally, noting that it can take many forms and is never OK • Summarize legal rights (protection, healthcare, immigration, asylum) • Note national hotline • Note services available across wide geographic areas • Introduce possible self-care techniques	How do our current printed materials take rapid and evolving movement into account?	What SGBV-related content would be appropriate given migrants' and refugees' rapid and evolving patterns of movement through the region?
DIVERSE DISPLACEMENT PROFILES	• Consult legal experts to identify key differences in legal rights according to displacement profiles • Note rights and resources both in-country and cross-border	How do our current printed materials take diverse displacement profiles into account?	What SGBV-related content would be appropriate given migrants' and refugees' diverse displacement profiles? Consider refugees, asylum seekers, IDPs, people in transit, returnees, migrants, etc.
LEGAL & SOCIAL INSECURITY & PROTECTION NEEDS	• Address legal rights (protection, healthcare, immigration, asylum) • Frame SGBV-related services as healthcare services available to citizens and non-citizens alike	How do our current printed materials take legal and social insecurity, protection needs into account?	What SGBV-related content would be appropriate given legal and social insecurity & protection needs for refugees and migrants?
PHYSICAL INSECURITY & PROTECTION NEEDS	• Note that services are private and confidential (if that can be said) • Minimize potential impression that holder of printed matter is a victim or plans to report crime • Offer easy-to-memorize information • Note national hotline • Use easily identifiable "safe" logos (eg, UNHCR, Red Cross)	How do our current printed materials take physical insecurity and protection needs into account?	What SGBV-related content would be appropriate given migrants' and refugees' physical insecurity, including risk of violence, and protection needs? How does this change during each phase of displacement?



Graphic forms can be effective ways to reach populations of mixed literacy levels.

This simple comic book called "Musu Goes to Court" was developed in Liberia by the Ministry of Justice and its partners to help explain the legal process to child survivors of sexual violence who may need to testify in court in Monrovia. The booklet was also viewed as helpful to adults who had little formal education.

Photo credit: Kim Thuy Seelinger

Provider brainstorm about dissemination

In addition to format and content of printed materials, providers could also take a fresh look at whether current methods of distribution can be improved generally and for SGBV-related materials in particular. Some questions to consider in that reflection include:

- What is the printed information (form and content) we currently have?
- Who is the intended audience and how do they travel?
- Are we currently reaching those groups effectively? Where can they be safely and reliably reached? Which potential partners are working in those locations, spaces (eg, organizations with mobile clinics)?
- How can printed material about SGBV be distributed to our different target audiences?
- What additional methods / sites of distribution should be considered for SGBV-related materials, given these target audiences? How can we ensure accessibility of materials for individuals with visual and hearing impairments?
- Who are natural partners for distribution in civil society and state institutions?
- How can we monitor and evaluate impact of our dissemination systems?

APPENDIX F | Facilitated Group Discussions

Facilitated group discussions, as among shelter residents or those in reception centers, can be an effective way to both enable SGBV disclosure and raise awareness about this form of harm and possible sources of assistance. Three promising methods of group engagement are the "Open-ended story" approach, the "Facilitator Cards for Community Discussion" approach, and the "Drama for dissemination" approach.

Open-Ended Story[1]

Open-ended stories provide a way to explore people's beliefs and present potentially sensitive topics for discussion, even among people with less formal education. In an open-ended story, facilitators leave out the beginning, middle, or ending of the narrative. Participants discuss the missing part of the story. They can be prompted by specific questions. This activity is best facilitated by two people: a main "storyteller" and a "guide" who can jump in to ask questions and help participants fill in the gaps. Though often used as a research method, this technique can easily be adapted to prompt discussion about difficult subjects in a pressure-free and collaborative way. Stories and questions can also create opportunities for facilitators to fill in gaps with important information, raising audience awareness.

Possible adaptation for Regional Safe Spaces Network

Below is a possible story to be used by shelter providers working with refugees and migrants along the Guatemala-Mexico corridor. Given the cultural taboos around SGBV, it may make sense to conduct this exercise with a group of women instead of a mixed audience. (Separate scenarios could be devised depending on whether women, girls, men, boys, people with diverse SOGI or other potential survivor groups are being targeted.)

ROSA

Rosa is from a town outside of Tegucigalpa, Honduras. She lived with her husband Raúl and her two children, Marta and Darwin, 9 and 6 years old. Raúl worked in construction and Rosa worked as a housewife caring for her children. Although Rosa completed 2 years of high school, Raúl didn't let her work because he was jealous and stated that it was his job to provide for the family. At times Raúl came home drunk and insulted and beat Rosa.

One night Raúl came home drunk and got very angry at Rosa for talking to their male neighbor. He beat her badly and left the house. Rosa immediately grabbed whatever she could fit into a backpack and took her children to the bus station where they headed north to the Guatemalan border. Rosa's sister, Yesenia, lives in in the USA and had always told Rosa to come join her. Rosa knew Yesenia would help her and planned to contact her once she got to Mexico City. From Guatemala, Rosa took another bus to the border. She and her children crossed a small stream about 500 yards from the immigration checkpoint and slipped into Mexico. Not knowing what to do, they started walking north to where Rosita had heard about organizations that help migrants and refugees.

After walking a couple of kilometers along the highway, a group of three men with machetes approached Rosita and her children. They said that they were vigilantes and that they work with Mexican Immigration. One man told her that he would turn them in unless she paid him something. When Rosa said she didn't have any money, the man threatened to call immigration unless she had sex with him. Worried about being sent back to face Raúl, she saw no other choice. After having sex with the man, Rosa continued walking north for another day until she met another group of migrants and refugees headed towards a shelter. She arrived at the shelter in the afternoon.

[1] Adapted from Mary Ellsberg and Lori Heise, *Researching Violence Against Women: A Practical Guide for Researchers and Activists* (Washington, DC: World Health Organization, PATH, 2005), 144.

Questions about Rosa:

1. How do you think Rosa felt right after her experience with the men with machetes?
2. When Rosa arrived at the shelter, what kind of help do you think she wanted?
3. Do you think Rosa would tell the shelter staff about what happened to her the day before, with the men with machetes? Why or why not?
    a. If you think she might not say anything, why do you think she would stay silent?
    b. If you think she might say something, what would she say? What would help her speak freely?
4. What kind of information would Rosa want from the shelter staff? What kind of person would she want to talk to?
5. What are Rosa's rights in Mexico?
    a. Can she get medical care?
    b. Can she report the attack to the Mexican police?
    c. Could any of her experiences of violence in Mexico (with the men with machetes) or Honduras (from Raúl) qualify her to apply for immigration status in Mexico now?
6. What else do you think people like Rosa want to know about how to get help while on the move?

Facilitator Cards for Community Discussion[2]

Community discussion and awareness raising activities can be made more dynamic and engaging with visual representations of key messages. When paired with a short list of two to three questions to stimulate reflection on an issue, facilitators can guide community discussion in a lively manner while communicating key messages about violence, community support, and available services.

Below is an example of a facilitator card from the Amani awareness raising campaign in Jordan.

Response to Violence

If you experience violence, now or at any time in the past, you have the right to receive help to stop the abuse. You also have the right to receive care and support from those around you. If someone you know is experiencing violence now, or has in the past, be supportive and help him or her to access relevant services.

Key Questions

1. What are the consequences of violence on women, girls, boys, and men? The family? The community?
2. Should women, girls, men, and boys (focus on each group) who experience violence in their family accept being subjected to violence? What about someone that is subjected to violence in the street or from a stranger?
3. How would you, or people around you, react to women, girls, boys, and men (focus on each group) experiencing violence?

Closing Remarks

Thanks a lot for your time! I hope you found our dialogue useful/interesting. Please come and join us in other activities *(provide some details and remember to share brochures or contact cards, and other relevant tools).*

Possible adaptation for Regional Safe Spaces Network

With a relevant graphic, a facilitator card may include discussion questions such as:

- What kinds of violence affect refugees and migrants in Central America – both in their home countries and while they are in transit? Are some forms of harm harder for people to talk about than others? Why?
- What would you tell someone traveling with you if they said they had suffered sexual violence? What kinds of help or information do you think they need? Where could they go for help?

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[2] Adapted from the Child Protection and SGBV Sub-Working Group's Amani Campaign in Jordan, https://reliefweb.int/sites/reliefweb.int/files/resources/AmaniImplementationguideEnglish%28online%29.pdf.

Drama for Dissemination

Drama-based activities can be an effective way of engaging an audience in discussion and disseminating information about a targeted issue. They can be conducted as a group activity at a shelter or even as an open event in a public space. They simply require a space where people can gather around, where it is not too noisy. This method is particularly helpful when working with children or people who have limited education.

The basic approach is simple: Actors (often staff members or volunteers recruited and prepared earlier) play out a short story that illustrates an issue targeted for awareness raising. For example, they may enact a scenario related to domestic violence or early marriage — taking care to avoid graphic detail, abrupt outbursts, or potentially triggering language or situations. A facilitator may "freeze" the story at certain points to pose questions to the audience — eg, "What is the protagonist feeling?" or "What should he/she do next?" or "Who can help?" Alternately, the actors may present the whole story and then ask questions to the audience at the end. Finally, actors / facilitators wrap up discussion by delivering the intended message and informing the audience about where to find further information or assistance. They can even pass out informational materials afterwards, if appropriate.

Redemption Hospital, Monrovia, Liberia

Our research in Liberia several years ago highlighted a wonderful example of the use of "drama for dissemination" at Redemption Hospital in Monrovia. There was a gender-based violence clinic in the hospital but it did not have a sign, in order to avoid exposure and stigmatization of patients. So, to spread community awareness about SGBV and the availability of support services, the clinic team presented dramas right in the main waiting room of the hospital. Once a week, actors would gather in the middle of the waiting area and enact mini-stories alluding to issues like domestic violence. They took care to avoid graphic detail — particularly since children were present. People who were already sitting there, waiting for appointments or visiting relatives, gathered around. They watched the drama and called out their thoughts afterwards when prompted. Clinic staff closed by announcing relevant information, along the lines of, "If anyone you know has these challenges, they may need medical care or counseling. Let them know they can come to this hospital and tell the entrance worker they need to see the gender team. They don't need an appointment and the meeting is private."

Activity challenges included a.) the need to "edit" SGBV scenarios for a public audience while still getting the message across, b.) absence of reference to, or services for, male or LGBTI survivors, and c.) potential sustainability issues due to limited staff time. However, on the whole, the Redemption Hospital team felt this approach was a helpful way to spread awareness about SGBV and what the hospital could offer in terms of services.

Possible adaptation for Safe Spaces Network

- Conduct a dramatic presentation as a group activity at a shelter or reception center. The presentation could illustrate a scenario involving a Honduran woman preparing to travel north and the things she is worried about, or her encounter with a border official or fellow traveler who proposes sex in exchange for assistance.
    - Questions could probe: "What kind of information or support does she need?" "Where can she go for help?" "What do you think would happen if she went to the police? Is she allowed to report this even if she is a foreigner?"
    - Shelter or reception staff can close by responding to audience comments as well as presenting information about SGBV, available services down the road, and legal rights. They can also distribute printed materials for participants to take with them. Staff should make sure to consider the accessibility of advertised services for women, girls, boys, men, LGBTI individuals, indigenous people, and people with disabilities.

- In some cases, similar drama-based outreach might be possible in public spaces where refugees and migrants gather, such parks or train and bus stations. However, care should be taken to avoid exposing refugees and migrants to unwanted attention from surrounding communit

APPENDIX G | Interventions for Highly Mobile Populations

Service provision for highly mobile populations is challenging in any context, as is disseminating crucial information about rights and services. While the Central and North American displacement context is certainly unique, service providers may find examples of interventions in other contexts useful to reference and possibly adapt. The tables below illustrate examples of two types of interventions used with highly mobile populations in other contexts: (1) service provision initiatives, and (2) communication campaigns.

Service Provision Initiatives

Lessons from Healthcare: HIV Care in South Africa

In South Africa, Médecins Sans Frontières (MSF) has developed a seven-step model of care for patients migrating across the South African-Zimbabwean border to ensure continuity of care for HIV. To help guide migrants, the model included providing migrants with a hand-held patient passport documenting current treatments and lab results, offering referral letters to patients who may choose to seek further care along their journey, and providing an "HIV road map" detailing where migrants can access treatment at their destination. On the service provision end, health workers asked about migrants' travel plans in adherence counselling sessions and provided patients with a three-month stock of drugs if they were planning on travelling for more than two weeks. Clinics also employed a questionnaire for new and returning patients that asked about continuity of treatment, utilizing a "transfer out" classification to avoid double-counting patients they had already seen.[1]

In addition, MSF has adopted several other outreach techniques, including offering health services in clinics that are near offices for asylum application, organizing primary healthcare mobile clinics to rural areas, and gathering information on patients' travel plans and coping mechanisms to help with creating an appropriate treatment regime and providing relevant referrals.[2] MSF has also noted that engaging private sector actors, such as companies that may employ irregular migrants, is important for improving access to health services.[3]

Lessons from Healthcare: mHealth Solutions

Health practitioners in Africa have used mobile health (mHealth) tools to promote health interventions such as HIV testing and pregnancy support to migrant populations.[4] MHealth solutions can also be applied in the mental health context to provide psychological support to at-risk populations.[5] For example, mobile phones have been used to provide services to mobile populations in South Africa, where the Department of Health built mHealth service MomConnect to educate and provide services to pregnant migrants. A similar South African program, Help@Hand, aims to inform refugees of access to legal and counselling services along the migratory route.[6] A study of mobile phone usage in Trans-Saharan migration notes that mobile phones often serve as crucial tools for African migrants and refugees to obtain information from their migratory "helpers" or access emergency financing along the route. However, the study also notes that mobile phone data can in turn be used by authorities to detect migrants.[7]

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[1] Médecins San Frontières, *Providing Antiretroviral Therapy for Mobile Populations: Lessons Learnt from a Cross Border ARV Programme in Musina, South Africa, Cape Town*, July 2012, http://www.msfaccess.org/sites/default/files/MSF_assets/HIV_AIDS/Docs/AIDS_report_ARTformobilepops_ENG_2012.pdf.
[2] Ibid.
[3] Aurélie Ponthieu and Andrea Incerti, "Continuity of Care for Migrant Populations in Southern Africa," *Refugee Survey Quarterly* 35 (2016): 113.
[4] Catrin Evans, K. Turner, L. S. Suggs, A. Occa, A. Juma, and H. Blake, "Developing a mHealth intervention to promote uptake of HIV testing among African communities in the conditions: a qualitative study," *BMC Public Health* 16, no. 1 (2016): 1–16.
[5] Matthew Price, Erica K. Yuen, Elizabeth M. Goetter, James D. Herbert, Evan M. Forman, Ron Acierno, and Kenneth J. Ruggiero, "mHealth: A Mechanism to Deliver More Accessible, More Effective Mental Health Care," *Clinical Psychology & Psychotherapy* 21, no. 5 (2014): 8.
[6] Ka Yan Leung and Wai Sze Leung, "Empowering Refugees and Migrants in South Africa through ICT4D," published in IST-Africa 2016 Conference Proceedings, 1–9, https://doi.org/10.1109/ISTAFRICA.2016.7530696.
[7] Max Leonard Schaub, "Lines across the desert: mobile phone use and mobility in the context of trans-Saharan migration," *Information Technology for Development* 18, no. 2 (2012): 126–44.

Communication Campaigns

Featured Refugee and Migrant Communication and Translation services[8]

Textfugees[9]
A text message service provision application for refugee service providers which parallels the mHealth model.

RefuComm[10]
Greek organization which creates audio and visual communication for refugees and trains "cultural mediators" to brief refugees on the immigration and relocation process.

Refugee Communication Boards[11]
One of many refugee translation services, this group uses simple icons on a gameboard-like layout to allow refugees to communicate with service providers.

ETCall[12]
A mobile app connecting refugees with volunteer translators.

Case Study: UNHCR refugee communication campaign in Macedonia[13]

In 2015, the UNHCR Emergency Lab interviewed refugees about their experiences at the border between Greece and Macedonia to determine the needs of refugees and migrants from the Middle East. The Emergency Lab then partnered with Translators Without Borders to translate responses to commonly asked questions which were then recorded and projected via existing loudspeakers at the former entry points from Greece into Macedonia. While the existing loudspeaker system required staff to manually go into the system to re-record new messages, it was soon replaced with a "smart" system that could be remotely controlled via tablet. With the help of Google, Mercy Corps, and others, the team created Translation Cards, an open source app which organizes FAQs into electronic decks that staff can access on their phones or tablets to answer questions in refugees' native languages. In addition, the UNHCR partnered with a private company to build centrally managed informational video programming for refugees along 11 television screens at border entry and exit points. The programming included cartoons for children and procedural information for their parents. The UNHCR also worked with Telecoms Sans Frontieres to set up internet connectivity at the southern Macedonian border and at a site in Serbia, allowing refugees to connect with their families and access electronic documents.

[8] Berkeley Refugee Resources (BRR), "Refugees - Translation, Interpretation, and Language Services," November 12, 2016, http://bev.berkeley.edu/refugees/translationservices.html.
[9] Textfugees project website no longer available; for more information on the initiative, see: Willa Frej, "Text Messaging May Solve One Major Problem In The Refugee Crisis," *Huffington Post*, March 14, 2016, https://www.huffingtonpost.com/entry/refugee-crisis-tech-techfugees_us_56dda2ffe4b0000de4052b8e.
[10] "RefuComm: About Us," 2018, http://www.refucomm.com/about.
[11] "Refugee Communication Boards," Tobii Dynavox, http://www2.tobiidynavox.com/refugee-communication-boards.
[12] ETCall, "Welcome to ETCall, the Simple App to Connect People Who Need Translation with Volunteer Translators through a Phone Call. #Syria #Refugees," Tweet, *@etcallde*, December 14, 2016, https://twitter.com/etcallde/status/809061902873661440.
[13] UNHCR Innovation Service, "Increasing Two-Way Communication with Refugees on the Move in Europe," *UNHCR Innovation*, September 1, 2017, http://www.unhcr.org/innovation/increasing-two-way-communication-with-refugees-on-the-move-in-europe.

APPENDIX H | Interview Guide and Fieldwork Schedule (November 2017)

Disclosing SGBV During Forced Displacement: Mexico / Guatemala
Nov 6-12, 2017: Tenosique, Palenque, Villahermosa, Mexico City / Mexico
Nov 13-14, 2017: Guatemala City / Guatemala

Key Informant Interviews

Semi-structured interview guide (approx. 75-90 minutes with translation)

Introduction

1. Provide overview of the project goals and methods, including UNHCR request to identify opportunities for improving SGBV disclosure among migrants and refugees on the move through Guatemala and Mexico who are served by partner organizations in UNHCR's Regional Safe Spaces Network.

Organizational Background

2. Ask for brief organizational background, including:
    a. Mandate of the organization;
    b. Description of the facility;
    c. Services provided;
    d. Roles and responsibilities of personnel within the organization;
    e. Populations served.

General profiles of migrant and refugee clients / populations served

3. Clarify general profiles of migrant and refugee population served, including:
    a. Whether organization serves men, women, or both;
    b. Whether LGBTI migrants and refugees are served;
    c. Whether children are served, and what ages;
    d. Trends around countries of origin and ethnic / linguistic backgrounds;
    e. Length of time migrants and refugees stay at the organization (if a shelter);
    f. Trends around travel patterns of migrant and refugee population served, i.e. whether they tend to be moving through the area quickly or staying for longer periods of time (if organization other than a shelter, eg, NGO or state actor).

SGBV and disclosure in the displacement context

4. Types of SGBV cases seen at the organization, including:
    a. Trends around forms of harm (eg, rape, forced nudity, transactional sex);
    b. Demographic trends of SGBV survivors seen by organization (eg, gender, age, national origin);
    c. Trends around specific risk factors for SGBV;
    d. Trends around where SGBV occurred (at home, in transit, in host country).

5. How do SGBV cases come to the attention of service providers / interviewees? Probe for:
    a. During intake or interview procedures?
    b. During medical or psychological evaluations with professionals?
    c. With non-professional staff, eg, with volunteers, cooks, security guards in common spaces?
    d. With other specific types of staff members or personnel (eg, religious counsel, psychologists, doctors)?
    e. Via peers (i.e. other migrants and refugees)?
    f. Through referral?

6. In the cases seen by providers, what factors have inhibited survivors from disclosing or served as barriers to disclosure? Probe for:
    a. Specific disclosure barriers with different population groups (eg, women, children, LGBTI individuals, men);
    b. Personal v. structural barriers to disclosure.

7. In the cases seen by providers, what factors have encouraged or motivated a survivor to disclose? Probe for:
    a. Needs related to SGBV or services sought for SGBV that motivated disclosure;
    b. Feelings of safety, trust, rapport with service provider.
        i. Follow up: how do service providers create a safe space or build trust and rapport with the people they serve?

8. What tools or techniques do service providers use to encourage disclosure? What additional trainings or other resources are available to service providers to help facilitate or encourage SGBV disclosure? Probe for:
    a. Methods used during interviews;
    b. Methods used in medical or psychosocial support settings;
    c. Methods used in group settings or common areas.

SGBV response services

9. What tools, trainings, or other resources are available to service providers re: SGBV response generally?

10. What challenges do providers face with SGBV response services?

11. What types of referral pathways are in place along the migration route? How are these coordinated and maintained? What challenges exist for referral?

SGBV awareness raising

12. What types of awareness raising tools and materials are used at the organization for communicating with migrants and refugees? Probe for:
    a. Printed materials;
    b. Murals or creative displays of information;
    c. Group discussions and activities;
    d. Digital or technological tools (eg, phones, internet, social media).

13. From what providers have observed among migrants and refugees, how are they obtaining information? Which methods of communication have been most effective for providers in their attempts to disseminate information about migrants' and refugees' rights, available services, and SGBV awareness raising in general? Probe for:
    a. Different methods effective among different population groups (eg, girls, boys, men, women, LGBTI individuals).

14. What ideas do providers have for communicating with migrants and refugees and raising awareness about SGBV? How can migrants and refugees that aren't seen by service providers be reached?

15. Are there any risks associated with certain forms of outreach or awareness raising to migrants and refugees?

General

16. What tools or trainings would be useful to service providers moving forward, for improving capacity to detect & respond to SGBV?

17. Other thoughts or final recommendations? Any questions?

Disclosing SGBV During Forced Displacement: Mexico / Guatemala

Field Mission Interviews

6 – 14 November 2017

Date	Time	Location	Interview Description
6-Nov-17	9:00am	Tenosique, MX	Initial meeting with UNHCR staff in Tenosique *Venue: UNHCR Field Office Tenosique*
6-Nov-17	9:30am	Tenosique, MX	La 72 *Venue: Hogar Refugio para personas migrantes La 72*
6-Nov-17	10:30am	Tenosique, MX	Médicos Sin Fronteras *Venue: MSF Office at the Hogar Refugio para personas migrantes La 72*
7-Nov-17	9:00am	Tenosique, MX	The RET *Venue: UNHCR Field Office Tenosique*
7-Nov-17	9:00am	Tenosique, MX	Asylum Access Mexico *Venue: UNHCR Field Office Tenosique*
7-Nov-17	12:00pm	Tenosique, MX	Community Hospital Tenosique *Venue: Community Hospital, Tenosique*
7-Nov-17	4:30pm	Palenque, MX	Local authorities from DIF Palenque *Venue: Casa del Migrante DIF, Palenque*
8-Nov-17	12:00pm	Palenque, MX	Casa del Caminante J'tatic Samuel Ruiz *Venue: Casa del Caminante J'tatic Samuel Ruiz*
9-Nov-17	11:00am	Villahermosa, MX	Centro DIF Colibrí *Venue: Colibrí Center, DIF Villahermosa*
10-Nov-17	11:00am	Mexico City, MX	Meeting with UNHCR national staff in Mexico City *Venue: Café near UNHCR office, Mexico City*
10-Nov-17	3:00pm	Mexico City, MX	Médicos Sin Fronteras *Venue: MSF office, Mexico City*
10-Nov-17	5:00pm	Mexico City, MX	Comisión Mexicana de Ayuda a Refugiados *Venue: COMAR office, Mexico City*

13-Nov-17	9:00am	Guatemala City, GUA	Informative session of UNHCR operations in Guatemala *Venue: UNHCR office, Guatemala City*
13-Nov-17	9:30am	Guatemala City, GUA	Meeting with partners of the National Safes Space Network in Guatemala. Present were: Pastoral de la Movilidad Humana, Casa del Migrante Misioneros Scalabrinianos, Asociación Lambda *Venue: UNHCR office, Guatemala City*
13-Nov-17	12:00pm	Guatemala City, GUA	Pastoral de la Movilidad Humana *Venue: Pastoral de la Movilidad Humana, Guatemala City*
13-Nov-17	3:00pm	Guatemala City, GUA	Casa del Migrante Misioneros Scalabrinianos *Venue: Casa del Migrante, Guatemala City*
14-Nov-17	8:30am	Guatemala City, GUA	Oficina de Derechos Humanos del Arzobispado de Guatemala *Venue: Albergue para personas en alto riesgo, ODHAG*
14-Nov-17	3:00pm	Guatemala City, GUA	Asociación Lambda *Venue: Espacio de Transición, Asociación Lambda*

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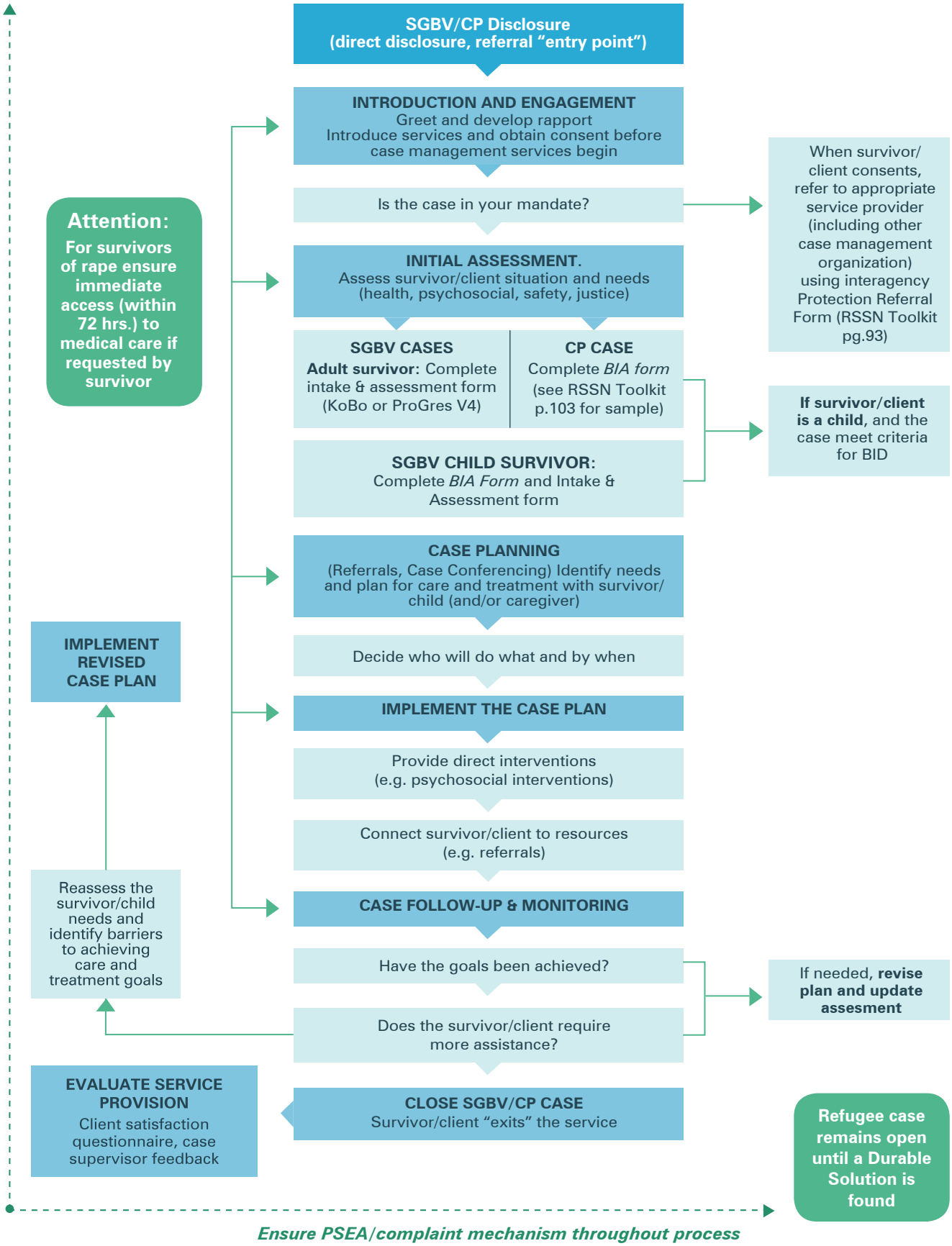
SGBV/CHILD PROTECTION CASE MANAGEMENT AND INFORMATION MANAGEMENT

TOOLS FOR CASE MANAGEMENT

CASE MANAGEMENT FLOWCHART
SGBV AND CHILD PROTECTION CASES

SEE NEXT PAGE ▶



(Adapted from Inter-Agency emergency standard operating procedures for prevention of and response to gender-based violence and child protection in Jordan 2013)

TEMPLATE
INTERAGENCY PROTECTION REFERRAL FORM

ES https://enketo.unhcr.org/x/#DH2QgPa0

SECTION 1: Individual information

proGres number/KOBO/Other identification: _____

Full name: _____ **Preferred name:** _____

Nationality: _____

Sex: ☐ Male ☐ Female ☐ Intersex

Gender: ☐ Male ☐ Female ☐ Other

Phone number: _____

SECTION 2: General

Referred by: _____

Due date: _____

SECTION 3: Referred to details

Service Type:
- ☐ SGBV/ Child Protection Case Management
- ☐ Health care
- ☐ Safety
- ☐ Mental health and Psychosocial Support
- ☐ Legal Assistance
- ☐ Cash assistance
- ☐ Accommodation
- ☐ Education
- ☐ Other

Referred to: _____

Is the case going to be transferred to another agency/country? ☐ Yes ☐ No

Which agency/country _____

Phone number: _____

Client's consent/Child's assent provided[1] ☐ Yes

SECTION 4: Authorization

Case Manager: _____ **Signature:** _____

Phone: _____ **Date:** _____

Authorizing manager: _____ **Signature:** _____

Phone: _____ **Date:** _____

1. Referrals and or Transfers should not be provided without the consent or assent of the affected individual

TEMPLATE
SGBV INTERAGENCY REFERRAL PATHWAY[1]

Referral Pathways reflect information as of beginning (month and year) and may have changed – Kindly seek out information regularly on potential changes

TELLING SOMEONE AND SEEKING HELP (DISCLOSING)

Survivor tells family, friend, community member, general service provider or at refugee registration services, reception and admission services; that person accompanies survivor to the health or case manager/psychosocial "entry point"	Survivor self-reports to a medical/health or case manager/ psychosocial "entry point"

IMMEDIATE RESPONSE

- Provide a safe, caring environment and respect the confidentiality and wishes of the survivor
- Provide reliable and comprehensive information on the available services and support to survivors of SGBV
- If agreed and requested by survivor, obtain informed consent and make referrals
- When family/guardians make a decision on behalf of the child, ensure the best interest of the child is given priority. Preferably, the accompanying adult should be selected by the child
- Accompany the survivor to assist him/her in accessing services
- For survivors of sexual violence ensure immediate (within 72 hrs) access to medical care

MEDICAL/HEALTH CARE:	CASE MANAGER (INCLUDING IMMEDIATE PSYCHOSOCIAL SUPPORT): **Adults (over 18)**	CASE MANAGER (INCLUDING IMMEDIATE PSYCHOSOCIAL SUPPORT): **Children (under 18)**
Organization name Service days Service hours Example: **NGO 1** Saturday – Thursday 09:00-16:00	**Organization name** Service days Service hours Example: **NGO 1** Saturday – Thursday 09:00-16:00	**Organization name** Service days Service hours Example: **Example NGO** 24 hours

1. This example is inspired on several inter-agency guidelines and tools, such as the Standard Operating procedures for prevention of and response to gender-based violence and violence, abuse, neglect and exploitation of Children in Jordan, 2014. Names of individuals and organizations used in this form have been created to serve as example and do not correspond to real identity information.

MEDICAL/HEALTH CARE:	**CASE MANAGER (INCLUDING IMMEDIATE PSYCHOSOCIAL SUPPORT):** **Adults (over 18)**	**CASE MANAGER (INCLUDING IMMEDIATE PSYCHOSOCIAL SUPPORT):** **Children (under 18)**
Focal Point: Name of the service provider Mobile: Email: Example: Dr. Pedro Lopez Mobile: 8523 8635 Email:pedor@exngo.org Organization name Service days Service hours Example: NGO 1 Sunday – Thursday 08:00 – 15 :30 Focal Point: Name of the service provider Mobile: Email: Example: Dr. Lia Perez Mobile: 9632 9999 Email: liap@exngo.org	Focal Point: Name of the service provider Mobile: Email: Example: Pedro Lopez Mobile: 8523 8635 Email: Pedro@exngo.org Organization name Service days Service hours Example: NGO 2 Sunday – Thursday 08:00 – 15 :30 Focal Point: Name of the service provider Mobile: Email: Example: Lia Perez Mobile: 9632 9999 Email: liap@exngo.org	Example: Pedro Lopez Mobile: 8523 8635 Email: james@exngo.org Organization name Service days Service hours Example: NGO 1 Sunday – Thursday 08:00 – 15 :30 Focal Point: Name of the service provider Mobile: Email: Example: Dr. Lia Perez Mobile: 9632 9999 Email: liap@exngo.org

IF ADULT SURVIVOR OR CHILD SURVIVOR/CAREGIVER WANT TO PURSUE POLICE/LEGAL ACTION - OR - IF IN THE BEST INTEREST OF THE CHILD – OR – IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS, refer and when possible accompany survivor to police/security - or - to legal assistance/ protection officers for information and assistance with referral to police .

PROTECTION, SECURITY, POLICE:

ORGANIZATION NAME
Service and specific information

Example:

UNHCR– Protection (including cases of risk of arrest, detention or refoulement)
Service days
Service hours

Example:
Sunday – Thursday 08:00 – 15:30

Focal Point:

Name of the focal point
Mobile:
Email:

Back Up :
Name of the back up Mobile/ Dutyphone:
Email:

Security: Always assess the consequences this decision could have and make sure that there are no risks for survivors

ORGANIZATION NAME
Service and specific information
Service days Service hours
Monday – Friday 08:00 – 17:30

Focal Point:
Name of the focal point Mobile:
Email:

Back Up :
Name of the backup Mobile/duty Phone:
Email:

LEGAL ASSISTANCE COUNSELLORS:

ORGANIZATION NAME
Service days
Service hours

Example:
UNHCR
Sunday – Thursday 08:00 – 15:30

Focal Point:
Name of the focal point
Mobile:
Email:

Back Up :
Name of the backup Mobile/duty phone:
Email:

ORGANIZATION NAME
Service days Service hours

Example:
NGO 1
Saturday – Thursday
09:00-16:00

Focal Point:
Name of the service provider
Mobile:
Email:
Emergency line:

AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's choices can include any of the following:			
Health Care	**Psychosocial Services (PSS)**	**Protection, Security, and Justice**	**Basic Needs (Cash, NFI, etc)**
PRIMARY HEALTH CARE: **ORGANIZATION NAME** Service days Service hours *Example:* **Hospital 1** 24 hours **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization	**PSS SERVICES FOR ADULTS:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO 1** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exngo.org or Tel. of the organization	**PROTECTION/ REGISTRATION:** **ORGANIZATION NAME** Service days Service hours *Example:* **UNHCR** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: or Tel. of the organization	**CASH/NFIS:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO2** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email:

Health Care	Psychosocial Services (PSS)	Protection, Security, and Justice	Basic Needs (Cash, NFI, etc)
REPRODUCTIVE HEALTH SERVICES: **ORGANIZATION NAME** Service days Service hours *Example:* **Hospital 1** 24 hours **Focal Point:** *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization	**MHPSS SERVICES FOR CHILDREN:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO 1** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exngo.org or Tel. of the organization	**SHELTERS/SAFE HOUSES:** **ORGANIZATION NAME** Service days Service hours *Example*: **Shelter 1** 24 hours **Focal Point:** Name of the service provider Mobile: Email: or Tel. of the organization	**FOOD ASSISTANCE:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO 3** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: **EDUCATION:** **ORGANIZATION NAME** Service days Service hours *Example:* **Save the children** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email

Health Care	Psychosocial Services (PSS)	Protection, Security, and Justice	Basic Needs (Cash, NFI, etc)
MENTAL HEALTH SERVICES: **ORGANIZATION NAME** Service days Service hours Example: **Hospital 1** 24 hours **Focal Point:** *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization	**CHILD FRIENDLY SPACES:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO 1** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization		**INFORMAL EDUCATION SERVICES:** **ORGANIZATION NAME** Service days Service hours *Example:* **NGO 2** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email:

TEMPLATE
CHILD PROTECTION REFERRAL PATHWAY*

CHILD PROTECTION REFERRAL PATHWAY – NAME OF THE LOCATION

Referral Pathways reflect information as of beginning ----- (month and year) and may have changed – Kindly seek out information regularly on potential changes

STEP 1: Identification of child protection cases	
General service providers, registration services or community members identify child protection case. Immediate response includes: • Provide a safe, caring response • Respect the confidentiality and wishes of the child/caregiver • Provide information about available case management services • Facilitate referral to relevant case management services (see below) when child/caregiver consents • For child survivors of sexual violence ensure immediate (within 72 hrs.) access to medical care • In case of immediate safety or security risk to the child, consult child protection case manager to determine child's best interest	**Child or caregiver goes directly to case manager**

** This example is inspired on several inter-agency guidelines and tools, such as the Standard Operating procedures for prevention of and response to gender-based violence and violence, abuse, neglect and exploitation of Children in Jordan, 2014. Names of individuals and organizations used in this form have been created to serve as example and do not correspond to real identity information.*

Gang violence against children	SGBV against children including sexual violence (see SGBV referral pathway)	All other CP cases including violence against children at home and the community	Unaccompanied & separated children	Child Recruitment	Child exploitation and child labor
Organization name Service days Service hours *Example:* **Save the children** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email:	**Organization name** Service days Service hours *Example:* **NGO 1** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email:	**Organization name** Service days Service hours **Focal Point:** *Example:* **UNHCR** Monday - Sunday 10.00 - 14.00 Name of the service provider Mobile: Email: or Tel. of the organization	**Organization name** Service days Service hours **Focal Point:** *Example:* **UNHCR** Monday - Sunday 10.00 - 14.00 Name of the service provider Mobile: Email: or Tel. of the organization	**Organization name** Service days Service hours **Focal Point:** *Example:* **UNHCR** Monday - Sunday 10.00 - 14.00 Name of the service provider Mobile: Email: or Tel. of the organization	**Organization name** Service days Service hours **Focal Point:** *Example:* **UNHCR** Monday - Sunday 10.00 - 14.00 Name of the service provider Mobile: Email: or Tel. of the organization

Case managers refer to services below if:

a. Child/caregiver wants to receive protection, legal or police services;
b. There are immediate safety and security risks to others;
c. It is in the best interest of the child because of:
   - Immediate safety or security risks to the child that require protection/ police services (and UNHCR or the relevant agency);
   - Risk of refoulement or voluntary return in cases of children associated with gangs (Maras), armed groups/forces (and UNHCR and/or the relevant agency)
   - Severe neglect (UNHCR/Child Welfare Agency)
   - Sexual exploitation and abuse by humanitarian personnel (and UNHCR or the relevant agency)
   - Children requiring Best Interest Determination (UNHCR/Child Welfare Agency)

Always assess the consequences this could have to minimize risks and ensure best interest of the child.

ORGANIZATION NAME
(Service and specific information)

Example:
UNHCR– Protection (including cases of risk of arrest, detention or refoulement)
Service days - Service hours

Example:
Sunday – Thursday 08:00 – 15:30

Focal Point:
Name of the focal point / Mobile: / Email:

Back Up :
Name of the back up: /Mobile/dutyphone: / Email:

STEP 2: Referral to other services

HEALTH CARE	CP PSYCHOSOCIAL SERVICES / CASE MANAGEMENT	PROTECTION, SECURITY, AND JUSTICE	OTHER BASIC SERVICES	EDUCATION[1]
Organization name Service days Service hours *Example:* **Hospital 1** 24 hours **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization **MENTAL HEALTH:** **Organization name** Service days Service hours *Example:* **Hospital 1** 24 hours **Focal Point:** Name of the service provider/ Mobile:	**Organization name** Service days Service hours *Example:* **NGO 1** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email: *Example:* Dr. Lia Perez Mobile: 9632 9999 Email: liap@exhos.org or Tel. of the organization	**Organization name** Service and specific information *Example:* **UNHCR-** Protection, Registration and legal services for refugees Service days Service hours *Example:* Sunday -Thursday 08.00 - 15.30 **Focal Point:** Name of the service provider Mobile: Email: **Back up:** Name of the back up: Mobile/duty phone: Email:	**Organization name** Service and specific information *Example:* **UNHCR-** Registration, support to vulnerable children and families through cash Service days Service hours *Example:* Sunday -Thursday 08.00 - 15.30 **Focal Point:** Name of the service provider Mobile: Email: **Back up:** Name of the back up: Mobile/duty phone: Email:	**Organization name** Service days Service hours *Example:* **OEI** Monday - Sunday 10.00 - 14.00 **Focal Point:** Name of the service provider Mobile: Email:

1. DEFINITIONS:
Formal education: Certified education services provided by the Ministry of Education public schools (grade 1–12).
Informal education: Educational activities that range from recreational activities to literacy numeracy, and life skills sessions. These educational activities are not certifed by the Ministry of Education and not specifically bound to certain age or target group.

BIA KOBO FORM

https://enketo.unhcr.org/x/#TQbS5caU

KoBo Toolbox

Best Interest Assessment (BIA) - RSSN Americas

INSTRUCTIONS	
THIS FORM MUST BE FILLED OUT BY THE PERSON PROVIDING SERVICES TO THE CHILD.	
REMIND THE CHILD AND CAREGIVER THAT ALL INFORMATION WILL BE KEPT CONFIDENTIAL, AND THAT THEY MAY CHOOSE NOT TO ANSWER ANY OF THE FOLLOWING QUESTIONS.	
CHILD PROTECTION CASE NUMBER	PARTNER ID

General Section

» BIA

BIA NUMBER *This number will be automatically generated*	OPENING DATE yyyy-mm-dd

SOURCE OF REFERRAL

- ◯ Reception
- ◯ RSD
- ◯ UNHCR Partner
- ◯ Person of Concern
- ◯ Other
- ◯ Registration
- ◯ Protection
- ◯ NGO
- ◯ Community Volunteer
- ◯ Resettlement
- ◯ Assistance
- ◯ Government
- ◯ Not a referral. This is a Transfer

REFERRAL DESCRIPTION
Please include any details regarding the referral and if this is a transfer, please specify the source (country, agency)

» OVERVIEW

MAIN PROTECTION RISK	SPECIFIC PROTECTION NEEDS
◯ Child at Risk ◯ Unaccompanied Child ◯ Separated Child	☐ Child victim of violence ☐ Child in detention ☐ Child with serious health condition ☐ Child associated with armed forces or groups ☐ Legal documentation ☐ Teenage pregnancy ☐ Other
MAIN PURPOSE OF BIA ☐ Alternative Care ☐ Family Tracing ☐ Family Reunification ☐ Resettlement ☐ Other	MAIN PURPOSE OF BIA DETAILS
BIA BY	BIA DATE yyyy-mm-dd
BIA LOCATION *Dropdown list customised*	PRIORITY ◯ Emergency ◯ High ◯ Medium ◯ Low

» INDIVIDUAL INFO

INDIVIDUAL REGISTRATION NUMBER		REGISTRATION GROUP
AGE *Only individuals who are less than 30 years old*	SEX ◯ Female ◯ Male ◯ Intersex	GENDER ◯ Female ◯ Male ◯ Other
COUNTRY OF ORIGIN ◯ Colombia ◯ El Salvador ◯ Guatemala ◯ Honduras ◯ Nicaragua ◯ Venezuela ◯ Other		
COUNTRY OF BIRTH ◯ Colombia ◯ El Salvador ◯ Guatemala ◯ Honduras ◯ Nicaragua ◯ Venezuela ◯ Other		
NATIONALITY ◯ Colombia ◯ El Salvador ◯ Guatemala ◯ Honduras ◯ Nicaragua ◯ Venezuela ◯ Other		
DISPLACEMENT STATUS AT TIME OF THIS BIA *Legal Status* ◯ Refugee ◯ Asylum Seeker ◯ Resident ◯ IDP ◯ Stateless ◯ Returnee ◯ On the move ◯ N/A		

Assessment Section

CARE ARRANGEMENTS
Details of the current care arrangement situation, e.g. with whom the child is currently living, the child's relationship with his/her caretaker and/or housemates, the child's views on the care arrangement.

PSYCHOSOCIAL
Details of the level of psychosocial needs, e.g. who does the child go to for help; does the child sleep well; does the child have any worries; does the child play with other children?

LEGAL AND DOCUMENTATION
Details of need for legal representation or legal counselling if the child has been in contact with the law (either in conflict with the law, child victim or witness)

BASIC NEEDS (FOOD, SHELTER, NFI, WASH)
Details of the types of core relief items required by the child (mattress, blankets, clothes, shoes, etc.).

PROTECTION AND SAFETY
Details of level of physical protection needs, e.g. if the child feels safe, if there have been any incidents of violence, neglect or abuse, the protection risks associated with the child's daily activities.

EDUCATION
Details of access to education activities, e.g. level of schooling, if the child attends school or any educational activities, if not, does the child want to go to school?

HEALTH AND NUTRITION
Details of heath situation, e.g. if the child feels sick or has any medical issues, if the child has access to medical services, details of any disabilities, and support needs.

OTHER NEEDS
Information on any other needs that are not covered elsewhere.

Interview Details

» INTERVIEW

PERSONS INTERVIEWED FOR THE BIA	INTERVIEW BY
INTERVIEW COMPLETION DATE yyyy-mm-dd	INTERVIEWER ORGANIZATION
LANGUAGE OF INTERVIEW ◯ Spanish ◯ English ◯ Other	
ADDITIONAL INTERVIEW INFORMATION	

» HOME VISIT

HOME VISIT CONDUCTED ◯ Yes ◯ No	HOME VISIT DATE
CHILD PRESENT DURING HOME VISIT ◯ Yes ◯ No	HOME VISIT COMMENTS

Summary and Recommendations

CHILD'S VIEWS

CAREGIVER'S VIEWS

SUMMARY OF THE ASSESSMENT

RECOMMENDATIONS
What is the main recommendation from this BIA?

BID REFERRAL NECESSARY

◯ Yes ◯ No

MAIN BID REFERRAL REASON

◯ Durable solution for UAC
◯ Durable solution for SC with additional risk
◯ Temporary Care Arrangement in exceptional circumstances
◯ Separation from parents of main caregivers against their will
◯ Family reunification with additional protection risk
◯ Exceptional circumstance

ACTION PLAN

» Referral Information

HAS THIS CHILD BEEN REUNIFIED WITH HER/HIS FAMILY?

◯ Yes ◯ No

ANY OF THESE REFERRALS/SERVICE IS GOING TO BE PROVIDED IN A DIFFERENT COUNTRY?

◯ Yes
◯ No

PLEASE PROVIDE DETAILS:

IS THIS **CASE** GOING TO BE **TRANSFERRED** TO ANOTHER AGENCY/COUNTRY?

◯ Yes ◯ No

PLEASE SELECT COUNTRY OF TRANSFER:

◯ Within the same Country
◯ Brazil
◯ Chile
◯ Colombia
◯ Costa Rica
◯ Ecuador
◯ El Salvador
◯ Guatemala
◯ Honduras
◯ Mexico
◯ Peru
◯ Trinidad and Tobago
◯ Venezuela
◯ Other

PLEASE PROVIDE DETAILS INCLUDING AGENCY AND REASON FOR THE TRANSFER:

Consent

PERSON NOT CAPABLE OF PROVIDING CONSENT
Please print name and provide signature and ID#

◯ Yes ◯ No

CONSENT PROVIDER
Dropdown list tbc

CHILD'S AGREEMENT / ASSENT

◯ Yes ◯ No

DOES THE CHILD AND CAREGIVER PROVIDE THE CONSENT TO SHARE HER/HIS NON-IDENTIFIABLE DATA IN YOUR REPORTS?

◯ Yes ◯ No

BEST INTEREST DETERMINATION REPORT*

SECTION 1: OVERVIEW

Camp/Location:	**linked cases:**
BID No:	**Case No:**
Registration No:	
Separation status of the child: ☐ Unaccompanied ☐ Separated ☐ Orphan ☐ None of the above	**Purpose of BID:** ☐ Durable solution ☐ Family reunification ☐ temporary case arrangements ☐ Separation from parent/caregiver ☐ Other

PRIORITY OF THE CASE	
☐ Emergency ☐ High ☐ Medium ☐ Low	**Reasons:**
Specific needs of the child	

CHILD'S BASIC BIO-DATA *(Refer to Registration Form)*	
	Where relevant, indicate if information is an estimate
FULL NAME	
ALIAS	
AGE	
GENDER	
DATE OF BIRTH	
PLACE OF BIRTH	
DATE OF ARRIVAL IN THE COUNTRY	
DATE OF ARRIVAL AT CURRENT LOCATION	
NATIONALITY	
ETHNICITY	
RELIGION	

** This report is extracted from the UNHCR Best Interests Determination Guidelines 2008 and the provisional release of the revised Best Interests Assessment & and Best Interests Determination Guidelines 2018*

CHILD'S BASIC BIO-DATA
(Refer to Registration Form)

			Where relevant, indicate if information is an estimate
REGISTERED ADDRESS			
CURRENT CAREGIVER			
RELATED CASE (S)			
LINKED BID(S)			
NAME OF FATHER			
NAME OF MOTHER			
SIBLINGS			
TRACING	**Started on**		
	Status		

INTERVIEWS

PERSON INTERVIEWED	NO. OF INTERVIEWS	DATE OF INTERVIEWS

	NAME	ORGANIZATION
Interviewer		
Reviewing Officer		
Interpreter		

DOCUMENTATION ATTACHED

1	
2	
3	

SECTION 2: OPTIONS AND RECOMMENDATIONS

PART I- BRIEF SUMMARY INFORMATION ON THE CASE

Please **briefly summarize** key issues, such as current care arrangement, information on parents and family, and the options under consideration.

PART II- HISTORY PRIOR TO FLIGHT/SEPARATION

Please record the child's recollections about the flight/separation, and evidence provided by persons close to the child (if interviewed). Indicate how this information has been verified.

PART III- CURRENT SITUATION

Please describe the current living situation of the child, to include:

- Current care arrangement, living conditions, safety, relationships with foster parents/ siblings/care-givers/other family members;
- Community networks, education and school attendance;
- Assessment of child's age and maturity, physical and mental health and any specific needs assessment.

Please state who has been contacted and who provided information, e.g. child, family, persons close to child, care-givers, teachers, neighbours, social workers/NGO staff.

PART IV- AVAILABLE OPTIONS & ANALYSIS

Please indicate all the available options and follow-up mechanisms and analysis of each. Please refer to all the factors included in the Annex 9 checklist in recommending what is in the child's best interests, under the following headings:

- Views of child
- Family and close relationships
- Safe environment
- Development and identity needs

FINAL RECOMMENDATION

Please provide the final recommendation and reasons.

Name of Assessor:

Signature of Assessor:

Date:

Comments by Reviewer to the report:

Name & Signature of Reviewer:
Date:

SECTION 3: PANEL DECISION

This section should be completed and signed at the BID panel sessions. The signed page should then be scanned in order to protect the information included, attached to sections 1 and 2 of the form and converted into a pdf document.

THE PANEL

- ☐ Approves the recommendations
- ☐ Defers decision (please explain why)
- ☐ Does not approve the recommendations (please explain why and provide the panel's recommendation)
- ☐ Reopens the case (please explain why, and who requested the reopening)
- ☐ Closes the case

FULL REASONS FOR DECISION

FOLLOW UP ACTIONS REQUIRED (DESCRIBE)

COMMENTS

SIGNATURE OF PANEL MEMBERS:

NAME	ORGANIZATION	SIGNATURE

DATE:

STANDARD SGBV INTAKE AND ASSESSMENT FORM*
KOBO VERSION

https://enketo.unhcr.org/x/#DX71gbjw

INSTRUCTIONS

1. THIS FORM MUST BE FILLED OUT BY THE PERSON PROVIDING SERVICES TO THE SURVIVOR.

2. REMIND THE SURVIVOR THAT ALL INFORMATION WILL BE KEPT CONFIDENTIAL, AND THAT THEY MAY CHOOSE NOT TO ANSWER ANY OF THE FOLLOWING QUESTIONS.

INCIDENT ID *

SURVIVOR CODE *

Administrative Information

STAFF CODE

INCIDENT REPORTED DATE *
yyyy-mm-dd

INCIDENT DATE *
yyyy-mm-dd

DOES THE SURVIVOR GIVE THE CONSENT TO SHARE HER/HIS NON-IDENTIFIABLE DATA IN YOUR REPORTS? *
- ◯ Yes
- ◯ No

SURVIVOR RECEIVED SERVICES AT THE TIME OF REPORT? *
- ◯ Yes
- ◯ No

survivor information

DATE OF BIRTH *
yyyy-mm-dd

SEX *
- ◯ Female
- ◯ Male
- ◯ Intersex

GENDER
- ◯ Female
- ◯ Male
- ◯ Other

COUNTRY OF ORIGIN *
- ◯ Colombia
- ◯ El Salvador
- ◯ Guatemala
- ◯ Honduras
- ◯ Venezuela
- ◯ Other

CURRENT CIVIL / MARITAL STATUS *
- ◯ Single
- ◯ Engaged
- ◯ Married
- ◯ Widowed
- ◯ Divorced
- ◯ Separated
- ◯ Common Law Married
- ◯ Other

NUMBER OF CHILDREN

IS THE SURVIVOR A PERSON WITH DISABILITIES?
- ◯ Yes
- ◯ No

IS THE SURVIVOR AN UNACCOMPANIED CHILD, SEPARATED CHILD, OR OTHER VULNERABLE CHILD? *
- ◯ No
- ◯ Unaccompanied Child
- ◯ Separated Child
- ◯ Other Vulnerable Child

DISPLACEMENT STATUS AT TIME OF THE INTERVIEW
- ◯ Refugee
- ◯ Asylum Seeker
- ◯ Resident
- ◯ IDP
- ◯ Stateless
- ◯ Returnee
- ◯ N/A

** Note: This form is based on the SGBV module of UNHCR's ProGres V4 and the GBVIMS intake assessment form, to be used as alternative solution when ProGres V4 is not available.*

Details of the Incident

COUNTRY OF INCIDENT *

- ◯ Brazil
- ◯ Chile
- ◯ Colombia
- ◯ Costa Rica
- ◯ Ecuador
- ◯ El Salvador
- ◯ Guatemala
- ◯ Honduras
- ◯ Mexico
- ◯ Peru
- ◯ Trinidad and Tobago
- ◯ Venezuela
- ◯ Other

SGBV AGAINST A PERSON OF DIVERSE SOGI?

- ◯ Yes
- ◯ No

» Type of Incident

PLEASE FOLLOW THIS PATH OF QUESTIONS TO SELECT THE TYPE OF INCIDENT/VIOLENCE
RAPE (NON-CONSENSUAL PENETRATION)
SEXUAL ASSAULT
PHYSICAL ASSAULT
FORCED MARRIAGE
DENIAL OF RESOURCES, OPPORTUNITIES OR SERVICES
PSYCHOLOGICAL / EMOTIONAL ABUSE

DID THE REPORTED INCIDENT INVOLVE PENETRATION? *

- ◯ Yes
- ◯ No

DID THE REPORTED INCIDENT INVOLVE UNWANTED SEXUAL CONTACT? *

- ◯ Yes
- ◯ No

DID THE REPORTED INCIDENT INVOLVE PHYSICAL ASSAULT? *

- ◯ Yes
- ◯ No

WAS THE INCIDENT AN ACT OF FORCED MARRIAGE? *

- ◯ Yes
- ◯ No

DID THE REPORTED INCIDENT INVOLVE THE DENIAL OF RESOURCES, OPPORTUNITIES OR SERVICES? *

- ◯ Yes
- ◯ No

DID THE REPORTED INCIDENT INVOLVE PSYCHOLOGICAL/EMOTIONAL ABUSE? *

- ◯ Yes
- ◯ No

PLEASE START OVER AT FIRST QUESTION BELOW **INCIDENT INVOLVEMENT** TITLE AND TRY AGAIN TO RECLASSIFY THE INCIDENT (IF YOU HAVE TRIED TO CLASSIFY THE INCIDENT MULTIPLE TIMES, ASK YOUR SUPERVISOR TO HELP YOU CLASSIFY THIS INCIDENT).

IS THE REPORTED INCIDENT A CASE OF GBV? *

- ◯ Yes
- ◯ No

NON-GBV INCIDENT (PLEASE SPECIFY)

INCIDENT LOCATION / WHERE THE INCIDENT TOOK PLACE *

- ◯ Survivor's home
- ◯ Perpetrators' home
- ◯ Checkpoint
- ◯ Detention Centre
- ◯ Immigration Centre
- ◯ International Border
- ◯ Market / Shopping Centre
- ◯ Police Station / Security
- ◯ Public toilets / Latrines
- ◯ Religious Centre
- ◯ Safe House (including casa de abrigo)
- ◯ School / Education Institution
- ◯ Shelter (including albergue)
- ◯ Street
- ◯ Transportation (bus, train, etc.)
- ◯ Work Place (Factory, Office)
- ◯ Other

WERE MONEY, GOODS, BENEFITS, AND / OR SERVICES EXCHANGED IN RELATION TO THIS INCIDENT ? *

- ◯ Yes
- ◯ No

TYPE OF ABDUCTION AT TIME OF THE INCIDENT

- ◯ None
- ◯ Forced Recruitment
- ◯ Trafficked
- ◯ Abduction / Kidnapping
- ◯ Smuggled
- ◯ Other

HAS THE SURVIVOR REPORTED THIS INCIDENT ANYWHERE ELSE?

- ◯ Yes
- ◯ No

PLEASE SPECIFY *

Alleged Perpetrator Information

NUMBER OF ALLEGED PERPETRATOR(S) / (PERPETRATOR TYPE) *

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ More than 3
- ◯ Unknown

AGE GROUP *

- ◯ 0-11
- ◯ 12-17
- ◯ 18-59
- ◯ 60+
- ◯ unknown

ALLEGED PERPETRATOR RELATIONSHIP WITH SURVIVOR *

- ◯ Intimate partner / Former partner
- ◯ Primary caregiver
- ◯ Family other than spouse or caregiver
- ◯ Supervisor / Employer
- ◯ Teacher / School official
- ◯ Service Provider
- ◯ Host Family
- ◯ Cotenant / Housemate
- ◯ Family Friend / Neighbor
- ◯ Other refugee / IDP / returnee
- ◯ Other community member
- ◯ Other
- ◯ No relation
- ◯ Unknown

MAIN OCCUPATION OF ALLEGED PERPETRATOR *

- ◯ Unknown
- ◯ Police
- ◯ Government Armed Forces
- ◯ Non-State Armed Actor
- ◯ Humanitarian Worker
- ◯ Other

Planned Action / Action Taken: Any action / activity regarding this report

WAS SURVIVOR REFERRED TO PSYCHOSOCIAL SERVICES? *

- ◯ Yes
- ◯ No - Service provided by your agency
- ◯ No - Service already received from another agency and/or prior to this visit
- ◯ No - Service not applicable
- ◯ No - Referral declined by survivor
- ◯ No - Service unavailable

SURVIVOR REFERRED TO:

WAS SURVIVOR REFERRED TO HEALTH / MEDICAL SERVICES? *

- ◯ Yes
- ◯ No - Service provided by your agency
- ◯ No - Service already received from another agency and/or prior to this visit
- ◯ No - Service not applicable
- ◯ No - Referral declined by survivor
- ◯ No - Service unavailable

SURVIVOR REFERRED TO:

WAS SURVIVOR REFERRED TO LEGAL AID SERVICES? *

- ◯ Yes
- ◯ No - Service provided by your agency
- ◯ No - Service already received from another agency and/or prior to this visit
- ◯ No - Service not applicable
- ◯ No - Referral declined by survivor
- ◯ No - Service unavailable

SURVIVOR REFERRED TO:

WAS SURVIVOR REFERRED TO A SAFE SHELTER / ACCOMMODATION?

- ◯ Yes
- ◯ No - Service provided by your agency
- ◯ No - Service already received from another agency and/or prior to this visit
- ◯ No - Service not applicable
- ◯ No - Referral declined by survivor
- ◯ No - Service unavailable

SURVIVOR REFERRED TO:

WAS SURVIVOR REFERRED TO CP SGBV CM SERVICES?	SURVIVOR REFERRED TO:
◯ Yes ◯ No - Service provided by your agency ◯ No - Service already received from another agency and/or prior to this visit ◯ No - Service not applicable ◯ No - Referral declined by survivor ◯ No - Service unavailable	
WAS SURVIVOR REFERRED TO LIVELIHOODS SERVICES?	SURVIVOR REFERRED TO:
◯ Yes ◯ No - Service provided by your agency ◯ No - Service already received from another agency and/or prior to this visit ◯ No - Service not applicable ◯ No - Referral declined by survivor ◯ No - Service unavailable	
WAS SURVIVOR REFERRED TO EDUCATION SERVICES?	SURVIVOR REFERRED TO:
◯ Yes ◯ No - Service provided by your agency ◯ No - Service already received from another agency and/or prior to this visit ◯ No - Service not applicable ◯ No - Referral declined by survivor ◯ No - Service unavailable	

ANY OF THESE REFERRALS/SERVICE IS GOING TO BE PROVIDED IN A DIFFERENT COUNTRY? *

◯ Yes
◯ No

PLEASE PROVIDE DETAILS: *

IS THIS CASE GOING TO BE TRANSFERRED TO ANOTHER AGENCY/COUNTRY? *

◯ Yes
◯ No

PLEASE SELECT COUNTRY OF TRANSFER: *

◯ Within the same Country	◯ Brazil	◯ Chile
◯ Colombia	◯ Costa Rica	◯ Ecuador
◯ El Salvador	◯ Guatemala	◯ Honduras
◯ Mexico	◯ Peru	◯ Trinidad and Tobago
◯ Venezuela	◯ Other	

PLEASE PROVIDE DETAILS INCLUDING AGENCY AND REASON FOR THE TRANSFER: *

✔ Submit

TOOLS FOR INFORMATION MANAGEMENT

SAMPLE SGBV/CP REGIONAL INFORMATION SHARING PROTOCOL (RISP)

Sample of Regional Information Sharing Protocol

PURPOSE

This regional information sharing protocol is to set out the guiding principles and describe procedures for sharing anonymous aggregated data on reported cases[25] of sexual and gender-based violence (SGBV) and children at risk within the Region.

RSSN members in the Americas recognize that sharing and receiving consolidated SGBV and Child Protection (CP) data will contribute towards improved inter-agency coordination, identifying and targeting gaps, prioritization of actions, and improved programming of prevention and response efforts. It may also result in improved advocacy efforts, increased leverage for fundraising and resource mobilization, and improved monitoring. All agencies will protect information to ensure that no harm comes to any survivor, child or the community from information sharing efforts.

GROUND RULES

Information submitted by signatories of this protocol to (**name of the entity)** will only be submitted in the agreed-upon format and will not contain any identifying information of survivors, children or organizations, unless for case management purposes[26] and in accordance with the safeguards established in this protocol. In some contexts, UNHCR will have a dual role as the data consolidating agency and a RSSN/RISP member responsible for data collection.

25. Refers specifically to overall numbers of reported incidents and transfers
26. Multi-country Case Management context

The information shared by entities as part to this protocol will be consolidated by the consolidating agency into national and regional reports. These reports may be shared externally, meaning with others outside those adhering to this information sharing protocol, only with written authorization and agreement from all RISP members. All RISP members agree to adhere to the terms in this protocol.

See Annex 1 for a list of names of all approved agencies/organizations/entities for data sharing.

Any survivor and child specific data that could lead to identification of the survivor will not be shared, e.g., name, initials, province, date of birth, etc.

When issuing regular reports of aggregated data or when written authorization for external aggregated data sharing is attained, **the consolidating agency** must share such data along with the following relevant caveats:

- **The data is only from *reported* cases.** The consolidated data is in no way representative of the total incidence or prevalence of SGBV and child protection risk in one location or group of locations.

- The aggregate data is based on quarterly consolidated reports submitted from UNHCR and partners for the purposes of:
  - SGBV prevention and response and Child Protection program planning, monitoring and evaluation
  - Identification of programming and service delivery gaps
  - Prioritization of actions and next steps
  - Improved service delivery
  - Policy and advocacy
  - Resource mobilization
  - SGBV and CP multi-country case management

QUARTERLY REPORTS[26] AND INFORMATION SHARING PROCEDURE

1. The RISP members will submit the quarterly report of aggregated numbers to the UNHCR focal point in the area. This report will then be sent to the consolidating agency.
2. The reports will be submitted the **(date)** of each quarter.
3. The reports will include data defined in the Quarterly Reporting Tables (see Annex 2)
4. One (1) week after receipt of the reports from RISP members (2nd week of the quarter), the consolidating agency.

26. See Annex to this document for list and samples of reporting tables.

5. Two (2) weeks after receipt of the reports from each **entity**, **(entity)** will consolidate all national reports. The aggregate report for each country operation and an aggregate report of regional data will be sent back to all RISP members identifying information deleted.
6. Areas of coverage: The aggregate reports will reflect the following geographical areas based on the RSSN members providing data.

DATA PROTECTION

Coordinators, focal points and members of the RISP will ensure that all data is safe and secure and will implement appropriate procedures to maintain confidentiality of the data. For example, each RSSN/RISP member (organization or agency) will ensure that they have already clarified and are implementing their internal data sharing protocols in accordance with data and information protection standards. Members will submit a filled template for that quarter (password protected excel file). The passwords for these submitted files will be agreed among issuing agencies and receptor (focal points).

the coordinating and consolidating agency has outlined during the creation of this protocol how the data will be:

- Received
- Shared (referred/transferred)
- Stored/deleted
- Protected in the computer
- Used by whom (who has access to the data and the computer) and for which purposes (Information management/case management)

COORDINATOR AND CONSOLIDATOR AGENCY

The quarterly reports are shared with consolidating entity of the RISP. In the event of changes in the coordination roles and responsibilities, the information sharing protocol will be reviewed by each of the RSSN/RISP members and signatories of this protocol.

WHEN OTHERS REQUEST SGBV/CP INFORMATION

All RISP signatories are authorized to use consolidated data for their internal reporting requirements. When sharing data for their internal reporting requirements, organizations and agencies must maintain data protection standards of confidentiality and security.

Each time external agencies or actors, not already approved for data sharing by the RISP members, submit a request for regional SGBV and CP information, **the Coordinator agency** will issue a written request to each of the RISP members for authorization to share data. Each request for authorization to share consolidated SGBV and/ or CP data will specify: the reason/purpose for the request for information, what the information will be used for and how the information will be used.

The consolidated data will be shared only after receiving authorization from all signatories to this protocol. When a request for authorization to share data is submitted by **the Coordinator**, the signatory organizations will respond through the national coordinators to the request within five (5) working days.

A party that has been authorized to receive consolidated SGBV and CP data must direct any request they receive for access to this shared data to the Coordinator of **(entity)**.

Names of non-signatory agencies / organizations / entities that have been approved to access consolidated data here:

AGENCY/ORGANIZATION/ENTITY	TYPE OF REPORT
	Quarterly Regional Report
	Quarterly Regional and National Report
	Quarterly Regional Report
	Annual Regional Report
	Annual Regional Report
	Annual Regional Report
	Annual Regional Report

By this information sharing protocol, the RISP members understand that they can refer any request for SGBV and CP consolidated information to the Coordinator of the **RISP** who can then share the data after receiving authorization from all RISP members in response to the written request.

TIME LIMIT

Once agreed, this information sharing protocol will take effect on **[DATE]**, and will be on trial basis until **[DATE]**, upon which the data gathering organizations will review the effectiveness of, use of and adherence to the protocol.

Data gathering organizations reserve the right to stop sharing data for any reason at any time, and will inform **[NATIONAL CONSOLIDATION AGENCY]** in writing if/when they do so.

BREACHES

In cases of breach by any of those participating in this information sharing protocol, information sharing will cease until resolved, responsible parties will be held accountable and the information sharing protocol will be reviewed.
The data gathering organizations reserve the right to refuse sharing information about SGBV reported cases to any external actor.

ANNEX 1
Names of all approved agencies/organizations/entities for data sharing

Name of entity

LOCATION	ORGANIZATION	FOCAL POINTS

RISP members

LOCATION	SERVICES PROVIDED TO SGBV SURVIVORS	FOCAL POINTS

ANNEX 2
Signatures of parties to the RISP

Name .....
Designation .....
Agency .....
Signature .....
Date .....

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Designation .....
Agency .....
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ANNEX 3
REPORTING TEMPLATE (also available in Excel)

The following tables are sample of tables to be shared by RISP members.

1. Number of Incidents by Type of SGBV, Age and Sex

	Age 0-11			Age 12-17			Age18-64			Age 65+			
TYPE OF SGBV	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**TOTAL**
Rape													
Sexual assault													
Physical assault													
Forced marriage													
Denial of resources, opportunities and/or services													
Psychological/ emotional abuse													
TOTAL													

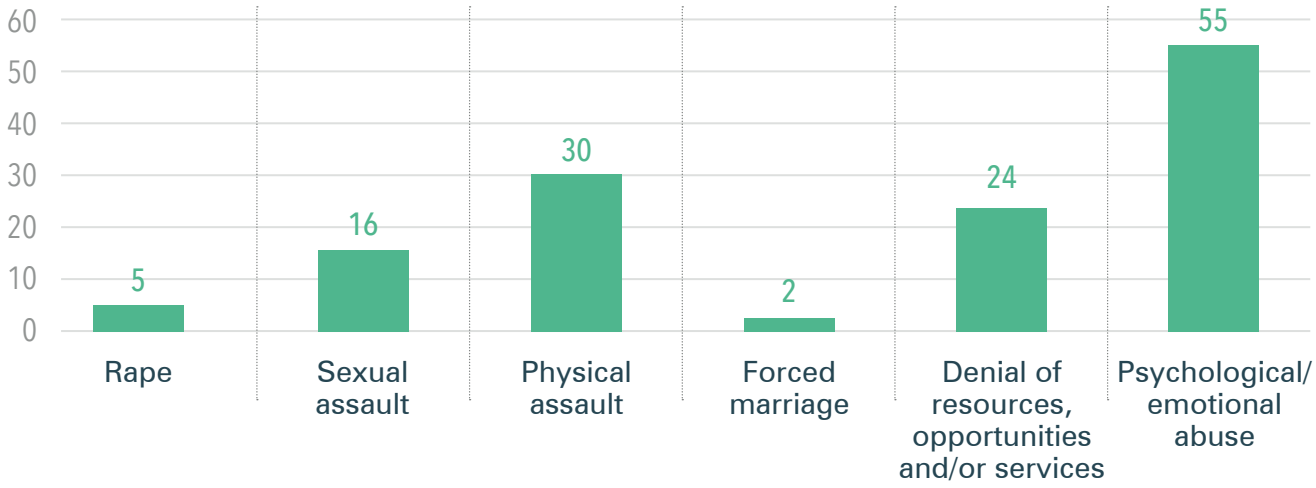
2. Number of Incidents by Violence against persons of diverse SOGI by type of SGBV, Age and Sex

	Age 0-11			Age 12-17			Age18-64			Age 65+			
TYPE OF SGBV	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**TOTAL**
Rape													
Sexual assault													
Physical assault													
Forced marriage													
Denial of resources, opportunities and/or services													
Psychological/ emotional abuse													
TOTAL													

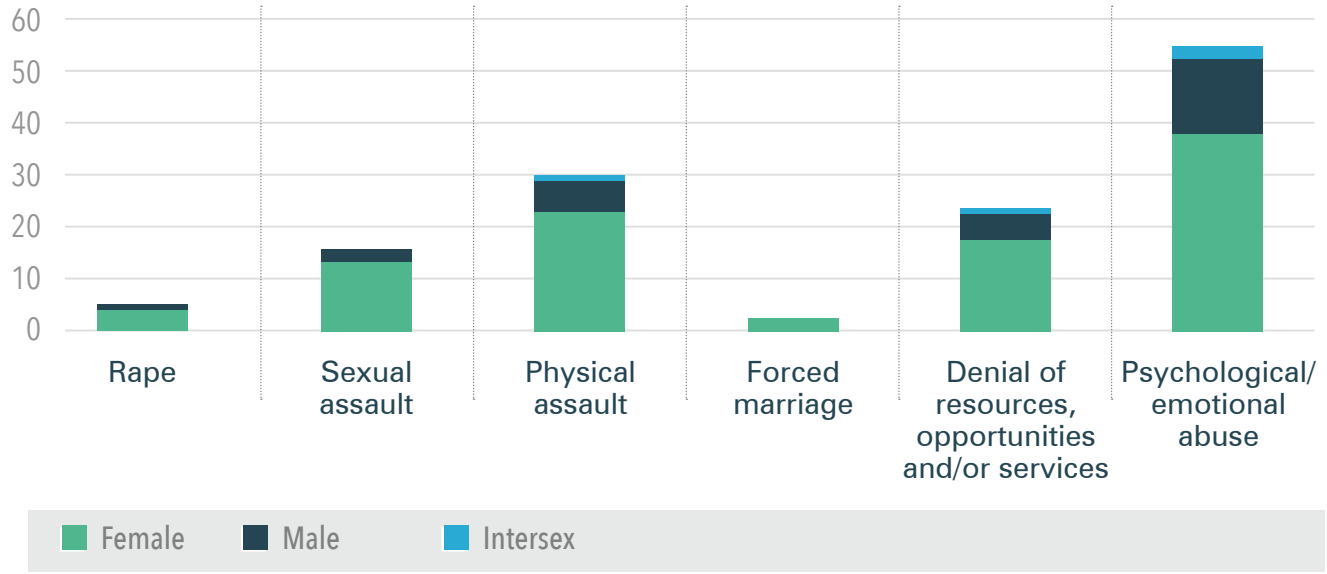
3. Number of Incidents by Violence by type of SGBV, Country of Origin and Sex

	Country 1			Country 2			Country 3			Other			
TYPE OF SGBV	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**F**	**M**	**I**	**TOTAL**
Rape													
Sexual assault													
Physical assault													
Forced marriage													
Denial of resources, opportunities and/or services													
Psychological/ emotional abuse													
TOTAL													

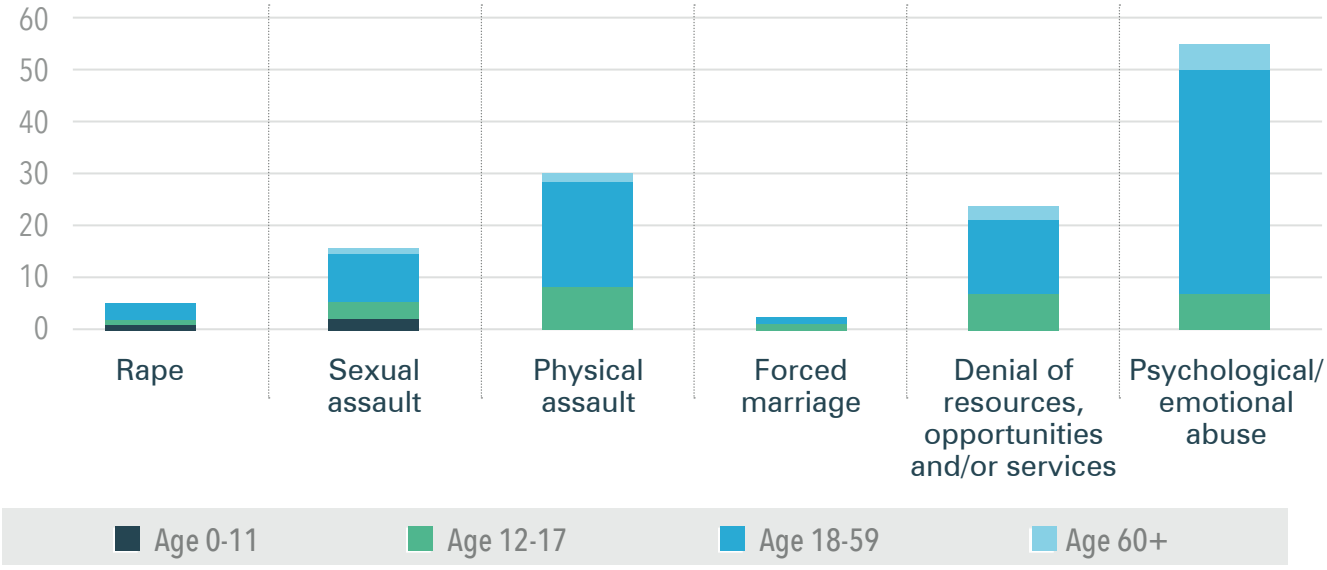
NUMBER OF INCIDENTS BY TYPE OF SGBV



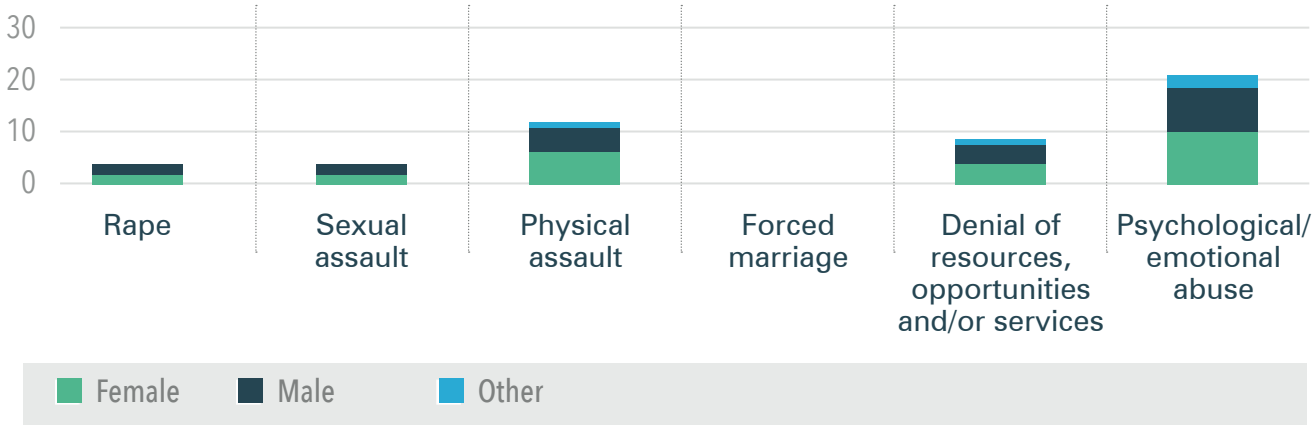
NUMBER OF INCIDENTS BY TYPE OF SGBV AND SEX



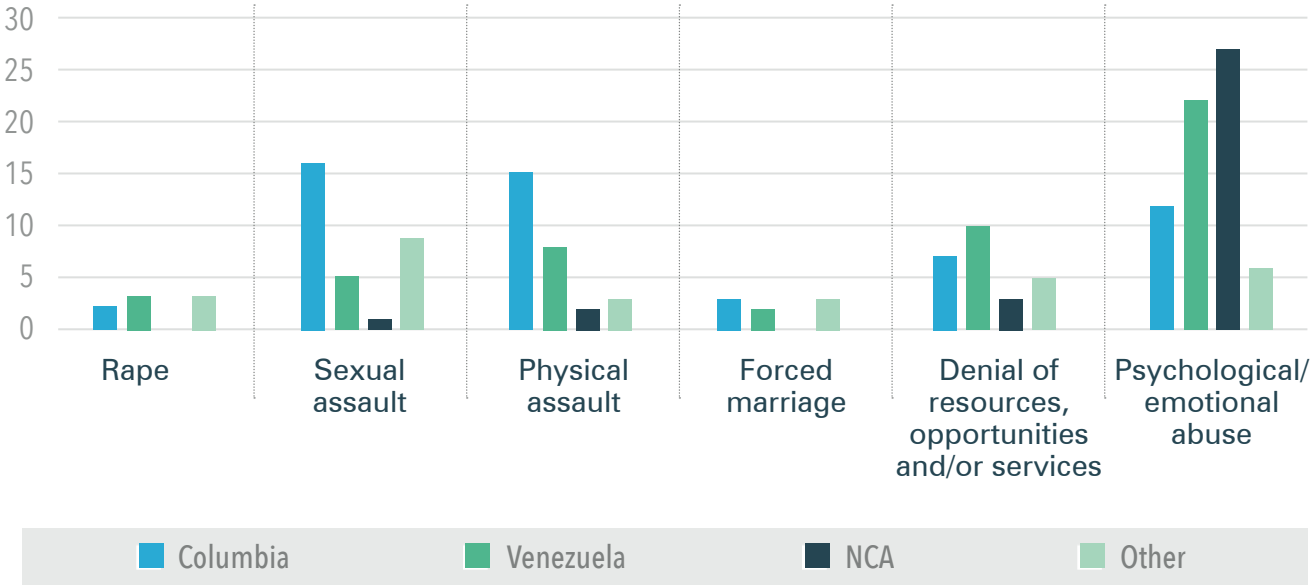
NUMBER OF INCIDENTS BY TYPE OF SGBV AND AGE



NUMBER OF INCIDENTS BY TYPE OF SGBV AND GENDER



REPORTED INCIDENTS BY TYPE OF SGBV AND COUNTRY OF ORIGIN



REGIONAL INFORMATION SHARING PROTOCOL IMPLEMENTATION ACTION PLAN

REGIONAL SAFE SPACES NETWORK
Country Operation: .....
Date: .....

INFORMATION SHARING PROTOCOL IMPLEMENTATION ACTION PLAN				
OBJECTIVE	**ACTIVITY**	**RESPONSIBLE ACTORS/ INDIVIDUALS**	**ACTORS/ INDIVIDUALS INVOLVED**	**DATES**
1-COORDINATION	Internal coordination meeting			
	Coordination meeting with partners			
	Identification of SGBV/CP information gaps			
	Selection of tools to obtain information			
	Selection of SBGV/CP IM Focal Points			
	RLU consultation process			
2. PLANNING	SGBV /CP case managers and service provider mapping			
	Consider personnel required			
	Data protection checklist			
	Implementation planning workshop			
	Modify tools			
	Incorporate in/align with protection strategy			
	Focal point training planning & preparation			
3. IMPLEMENTATION	Focal point training			
	Organizations train key staff			
	Data collection begins			
	Data compilation begins			
4. MAINTENANCE	Initial refresher training			
	RISP review meetings			
	RSSN coordination group meetings			
	RSSN at local, national and regional levels			
	Refresher trainings			

SAMPLE SOPS FOR SGBV DATA PROCESSING

Note: This is a sample living document that can be used as a template for the SOPs on the SGBV module in ProGres v4, which can be adapted and/or contextualized to the needs and situation of each operation.

Sample SOPs for SGBV Data Processing (Americas)

TABLE OF CONTENTS

SAMPLE SOPS FOR SGBV DATA PROCESSING (AMERICAS)

1.1 | Procedure for requesting user access rights to the SGBV module

The SGBV module is a case management tool for UNHCR and partner Protection staff with responsibility for SGBV case management. User access rights for the SGBV module in proGres v4 are limited and, in each operation, the UNHCR Protection Officer at national level is responsible for reviewing each request for user access before approval is granted.

UNHCR Protection Staff:

1. The **UNHCR Protection Officer** designates the UNHCR Protection staff members with SGBV focal point and back up focal point responsibilities based on SGBV case management knowledge and experience.
2. The **UNHCR Protection staff member** emails the **proGres v4 focal point** in the UNHCR National Office or Branch Office to request user access rights to the SGBV module **with their Protection Officer and Head of Office in copy**.
3. The proGres v4 focal point in the operation (Requesting User) fills out the Single proGres v4 User Access Form or Multiple proGres v4 Users Access Form and emails it to the ranking UNHCR Protection Officer in the National or Branch Office (Approving User) for review.
4. The UNHCR Protection Officer in the National or Branch Office reviews the level of user access rights according to the responsibility level of the Protection staff member. Additional information is requested as necessary.
5. When approval is granted, the proGres v4 focal point emails the Request Form to the Global Service Desk
6. The **proGres v4 focal point** advises the UNHCR Protection staff member with the Protection Officer, Head of Office in the field and national level Protection Officer in copy accordingly:
    a. No access granted and reasons why.
    b. Access granted.

Partner Staff:

1. The **Partner Supervisor** designates the staff members with SGBV focal point and back up focal point responsibilities based on SGBV case management knowledge and experience.
2. The **Partner staff member** emails the **proGres v4 focal point** in the UNHCR National Office or Branch Office to request user access **with the Partner Supervisor in copy**.

3. The **proGres v4 focal point** in the operation (Requesting User) fills out the Single proGres v4 User Access Form or Multiple proGres v4 Users Access Form and emails it to the ranking UNHCR Protection Officer in the National or Branch Office (Approving User) for review.
4. The **UNHCR Protection Officer in the National or Branch Office** reviews the requested level of user access rights according to the responsibility level of the **Partner staff member**. Additional information is requested as necessary.
5. When approval is granted, the **proGres v4 focal point** emails the Request Form to the Global Service Desk
6. The **proGres v4 focal point** advises the Partner staff member accordingly with the Partner Supervisor, UNHCR Protection Officer at national level and Head of Office in the field in copy:
    a. No access granted and reasons why.
    b. Access granted: User ID and login information shared.

1.2 | Opening an SGBV case in proGres v4

During the SGBV case management process, the details of an SGBV case or incident and the required follow up actions related to the case can be recorded, monitored and updated on an ongoing basis.

1.2.1 OBTAINING INFORMED CONSENT

The trained interviewer must obtain the informed consent of the SGBV survivor to:
1. Share information with other service providers;
2. Share anonymous information about the incident for reporting purposes.

A Consent Form must be filled out and signed by the survivor and the survivor's wishes related to information sharing can be recorded in the case record (see section **1.6 How to record Consent**).

1.2.2 WHEN TO OPEN AN SGBV CASE IN PROGRES V4

Open an SGBV case[1] in the following scenarios:

1. The survivor reports an SGBV incident (discloses) to the Protection focal point responsible for receiving SGBV cases.
2. The survivor is present at the time of reporting an SGBV incident.
3. A survivor reports an SGBV incident (discloses) while receiving services (e.g. psychosocial support, legal assistance, medical/health services, SGBV case management, safe shelter, security and protection services, etc.).

1. proGres in Partnership User Guide: SGBV Protection.

4. A trained UNHCR or partner Protection staff member has received an SGBV case referral in order to provide SGBV case management services.
5. A trained UNHCR or partner Protection staff member has been assigned the SGBV case and has user access rights to proGres v4 SGBV module;
6. For child survivors, open a Child Protection case. Each child who is an SGBV survivor requires a Best Interests Assessment (BIA). This form is found in the CP module.
7. **DO NOT OPEN AN SGBV CASE** if specialized services are unavailable to the survivor. It is unethical to collect the information of an SGBV survivor that is not receiving services. A survivor should be referred to a qualified Protection staff member (UNHCR or partner) as soon as possible to ensure appropriate follow up and case management.
8. **DO NOT OPEN AN SGBV CASE** if an SGBV incident is reported by a third party. In such case, other approprite follow up by the Protection staff will be required.

1.2.3 OPENING (CREATING) A SGBV CASE

To create a new SGBV Case follow these steps:

1. Click on the **Main Menu** button and go to the **Registration module**.
2. Expand the **Registration navigation** group and click on **Individuals** to open the Individuals main grid.
3. Select or open the desired Individual record.
4. Click on **Create SGBV Case**.
5. A **New SGBV Case** form opens.
6. You will notice that three additional sections are included to this form: **SGBV Incident**, **SGBV Alleged Perpetrator**, and **Incident Location** so that information about the main incident, perpetrator, and incident location are captured at the same time as the creation of the SGBV Case.
   Make sure that you have all the necessary information before you try to open the case.

RULES

- **There must be at least one *non-Erroneous* SGBV Incident associated to an *Active*, *Hold*, or *Inactive* SGBV Case.**
- **There must be at least one non-Erroneous SGBV Alleged Perpetrator and Incident Location associated to an *Active*, *Hold*, or *Inactive* SGBV Incident.**

7. Enter the desired and mandatory information. In the Incident section, select one of the following Incident sub-types:
   a. Rape
   b. Sexual assault
   c. Physical assault or abuse
   d. Forced marriage
   e. Denial of Resources, Opportunities and Services

f. Psychological / Emotional Abuse
All caseworkers entering SGBV cases/incidents should be trained on the GBVIMS classification of SGBV incidents, even if they are not using the full set of GBVIMS tools. The GBVIMS Classification tool provides a systematic and harmonized way of recording incidents.

8. Click on **Save** or **Save & Close**.
9 The SGBV Case is created for the selected Individual.
10 In addition, an SGBV Incident, an SGBV Alleged Perpetrator and an Incident Location are created using the information provided in the corresponding sections of the New SGBV Case.

Note that only mandatory fields for the Incident, Alleged Perpetrator and Location are displayed in the case creation form *– to enter additional information (e.g. incident description), you will need to open the individual records after you have created the case.*

1.2.4 MANDATORY AND OPTIONAL FIELDS

Information relevant to the operation:
All mandatory fields are marked with a red asterisk (*). A new SGBV case record can only be saved and created after all mandatory fields contain information. Relevant fields for this operation include both mandatory and optional fields:

GENERAL

Individual Info is entered during Registration.

Specific needs: The SGBV Case will need to be created and saved before a new or additional Specific Need can be added. Approved codes for the operation below:

Recent Contact

Field Name	Action required
Last Seen Date	• Enter the date of the most recent SGBV interview
Last Seen by	• Enter the name of the last known interviewer (the case manager): ○ UNHCR Protection staff with SGBV case management responsibility (proGres user) ○ Partner staff with SGBV case management responsibility (proGres user)

***Note:** UNHCR will not ask for confidential case information from partners who are the SGBV case management organization (proGres users or non-proGres users).*

INCIDENT

Incident Details:
(See section 1.2.1 How to determine Incident Type and Incident Sub-Type)

Alleged Perpetrator:
(See section 1.3 Alleged Perpetrators)

Incident Location:
(See section 1.4 Incident Location Type vs. Incident Location)

CASE NARRATIVE

Complete the optional fields:

Field Name	Action required
Case Summary	• Enter a brief narrative to explain the current state of the SGBV case.
Personal History	• Enter narrative to explain protection-relevant past events.
Comments	• **New**: Additional comments can be entered. • **Protected**: Default setting is **"No"**. Select **"Yes"** if the comments should be protected and only visible to the case owner and supervisor(s).

Create and save the SGBV case to enter additional information in:

- ***SGBV Assessments***
- ***Incidents***
- ***Counselling***

ACTION PLAN

Complete the optional fields:

Field Name	Action required
Action Plan Description	• Enter narrative to explain planned future actions to be taken by UNHCR, partners, government agencies or the survivor. Includes explanation why some actions have NOT been taken.

Create and save the SGBV case to enter additional information in:

- ***Interventions***
- ***Referrals:*** (See section 1.6 Referral of an SGBV Case)

OTHER DOCUMENTATION

***Note**: Documents saved under this section in the SGBV module are **VISIBLE** to any proGres user that accesses the individual case record through any other module.*

1.2.5 HOW TO SET THE CASE PRIORITY LEVEL (CASE DETAILS)

Opening Date:
Date you created the new SGBV case will be automatically entered

Information relevant to the operation:
Priority levels and follow up required

- Emergency
  - **Child:** Recommended response before leaving the child or within 24 hours and follow-up twice per week.
  - **Adult:** Recommended response within 72 hours for an adult and follow-up in coordination and agreement with the adult survivor.
- High – **Child/Adult:** Case priority is considered urgent and a response is recommended within 3 days and weekly follow up.
- Medium – Child/Adult: Recommended response within 1-3 weeks and follow up every 2 weeks to 1 month.
- Low – Requires response and periodic follow up.

1.3 | Opening an SGBV case in proGres v4

An SGBV incident must be recorded in order to open a new SGBV case. Only one SGBV incident can be recorded at a time.

1.3.1 HOW TO DETERMINE INCIDENT TYPE AND INCIDENT SUB-TYPE

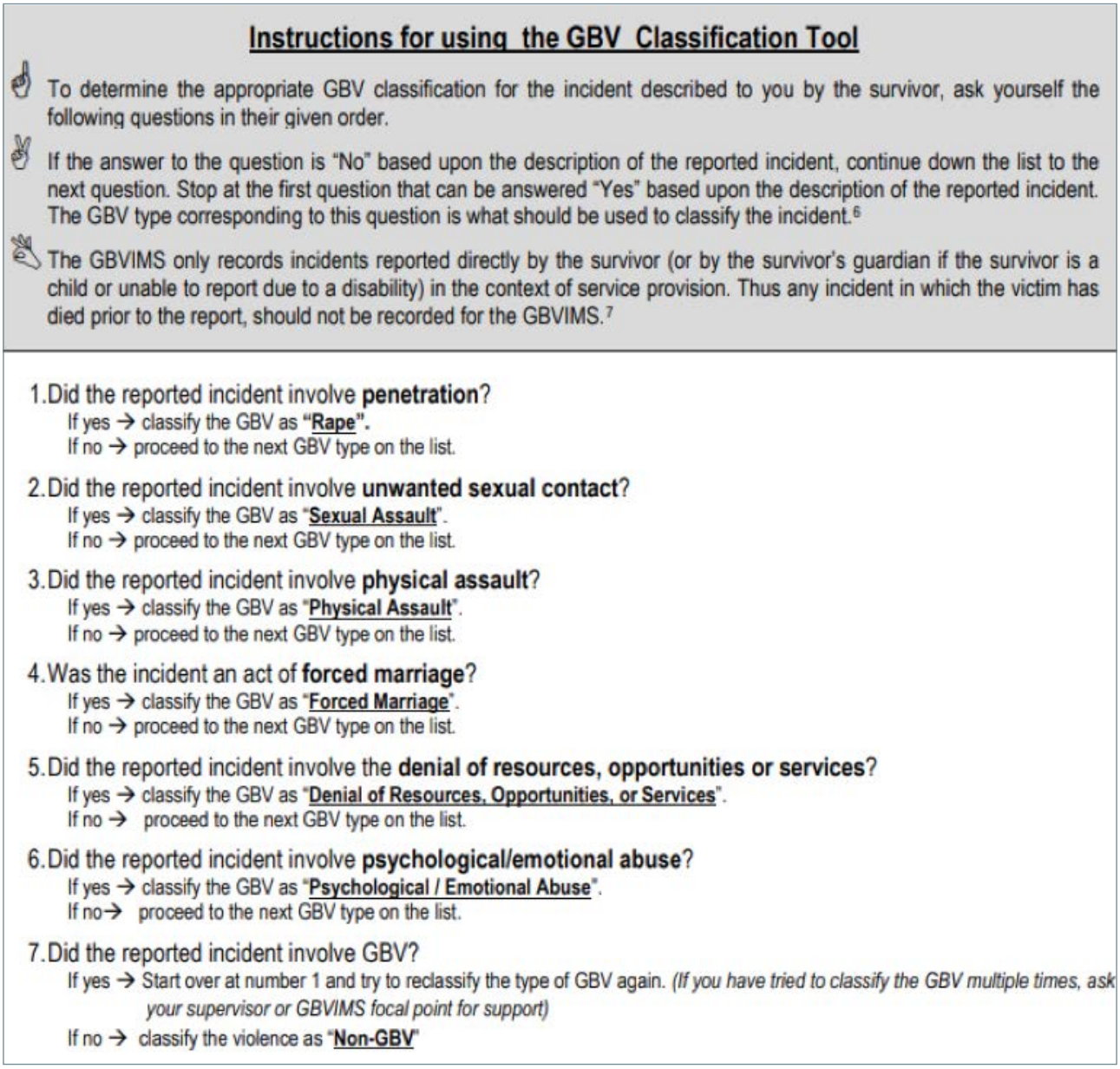
Incident Details

1. Single incident: Create a new incident for each separate SGBV incident. Incidents occurring in the past (several days, months or years ago) can be recorded as separate incidents.

Field Name	Action required
Incident Type	• For all SGBV incidents, type in or click on the search icon and select **"Freedom from Violence and Torture"**.

Field Name	Action required
Incident Sub-Type	• Select one of the 6 Sub-Types based on the SGBV Classification Tool questions (see Figure 1).

Figure 1: SGBV Classification Tool used to select the type of SGBV for each incident (Incident Sub-Type in proGres v4).



Instructions for using the GBV Classification Tool

To determine the appropriate GBV classification for the incident described to you by the survivor, ask yourself the following questions in their given order.

If the answer to the question is "No" based upon the description of the reported incident, continue down the list to the next question. Stop at the first question that can be answered "Yes" based upon the description of the reported incident. The GBV type corresponding to this question is what should be used to classify the incident.[6]

The GBVIMS only records incidents reported directly by the survivor (or by the survivor's guardian if the survivor is a child or unable to report due to a disability) in the context of service provision. Thus any incident in which the victim has died prior to the report, should not be recorded for the GBVIMS.[7]

1. Did the reported incident involve **penetration**?
   If yes → classify the GBV as "**Rape**".
   If no → proceed to the next GBV type on the list.
2. Did the reported incident involve **unwanted sexual contact**?
   If yes → classify the GBV as "**Sexual Assault**".
   If no → proceed to the next GBV type on the list.
3. Did the reported incident involve **physical assault**?
   If yes → classify the GBV as "**Physical Assault**".
   If no → proceed to the next GBV type on the list.
4. Was the incident an act of **forced marriage**?
   If yes → classify the GBV as "**Forced Marriage**".
   If no → proceed to the next GBV type on the list.
5. Did the reported incident involve the **denial of resources, opportunities or services**?
   If yes → classify the GBV as "**Denial of Resources, Opportunities, or Services**".
   If no → proceed to the next GBV type on the list.
6. Did the reported incident involve **psychological/emotional abuse**?
   If yes → classify the GBV as "**Psychological / Emotional Abuse**".
   If no → proceed to the next GBV type on the list.
7. Did the reported incident involve GBV?
   If yes → Start over at number 1 and try to reclassify the type of GBV again. *(If you have tried to classify the GBV multiple times, ask your supervisor or GBVIMS focal point for support)*
   If no → classify the violence as "**Non-GBV**"

2. Multiple types of SGBV during one incident can be recorded in the Case Narrative and SGBV assessment sections. For purposes of data collection, the SGBV Classification Tool is used to select one type of SGBV for an incident. The classification of the incident for data collection purposes does change how a caseworker would create an action plan with the survivor to address urgent follow up issues and specific needs.

1.3.2 MULTIPLE SGBV INCIDENTS

1. **Multiple SGBV incidents - same survivor, same perpetrator:** The caseworker will have to decide if this should be recorded as one or multiple incidents. Start with the incident the survivor is seeking assistance for during the current interview.
2. **Multiple SGBV incidents - same survivor, different perpetrators:** Record the current SGBV incident being reported. The caseworker can record each previous incident as a separate SGBV incident if the survivor has provided enough information to fill all mandatory fields. However, the survivor should not be pushed for details of previous incidents.
3. **Multiple SGBV incidents at the same time to separate survivors (by the same or different perpetrators):** Enter at least one incident per survivor. If an incident involves more than one survivor at more or less the same time, SGBV incidents can be linked using the Linked Grids entity and a list of **Linked Incidents** will appear in each survivor's case record.
4. **Ongoing SGBV incidents:** Examples of ongoing SGBV incidents may be domestic violence, survival sex or the threat of SGBV (i.e. child marriage, female genital mutilation, removal from school, etc.). Create one SGBV incident and select the Incident Sub-Type using the SGBV Incident Classification Tool.
5. **Incident linked to ongoing incident:** An additional incident can be entered, at the discretion of the case manager, if the most recent incident related to why the survivor has come to seek services differs from the ongoing incident (e.g. ongoing incident type = physical assault; most recent incident linked to ongoing incident = sexual assault). Furthermore, an additional incident could be entered at the discretion of the case manager if the incident linked to the ongoing incident occurred in the past and the survivor discloses this information (e.g. ongoing incident = physical assault; incident last year linked to ongoing incident = rape).

Field Name	Action required
Incident Start Date	• Same as Date of Incident. If the incident is a type of SGBV that is still ongoing, the start date can be recorded as an estimated or known date in the past.
Incident Occurrence	• Select **Occurred** if domestic violence is ongoing. Select **At Risk** if the incident being reported is a threat of SGBV.

***Note:** For determining how many incidents to record, use a survivor-centered approach. A survivor is not required to provide detailed information about the incident that occurred. If full details are not provided about other incidents in the past, the case manager **should not** push for more information for purposes of data collection. Entering additional incidents is not required.*

1.4 | Alleged Perpetrators

Separate records can be created within an SGBV case record of one or more alleged perpetrators of SGBV. The case worker will have to use discretion and a survivor-centred approach **to determine how many incidents should be recorded** based on the details of the case shared willingly by the survivor. This will depend on the number of alleged perpetrators, survivors and the given period of time.

1.4.1 DIFFERENT NUMBERS OF ALLEGED PERPETRATORS OR SURVIVORS

1. One alleged perpetrator: fill in the mandatory fields and estimate age if alleged perpetrator type is an identifiable individual.
2. One alleged perpetrator, multiple incidents: create a new incident record for each incident. This applies to one survivor or if there were multiple survivors.
3. Multiple alleged perpetrators, one survivor: Add each alleged perpetrator in a separate record under Alleged Perpetrators if they are identifiable individuals

Field Name	Action required
Alleged Perpetrator Sex	• Options: Male, Female, Other, Unknown. Select **"Other"** if the known sex of the perpetrator was not male or female. Select **"Unknown"** if the perpetrator was unidentifiable and the sex was unknown.
Relationship to Victim/Survivor	• If there are multiple relationships between the Survivor and the Perpetrator including Intimate Partner, select **"Intimate Partner / Former Partner"**.
Perpetrator Type	• If the perpetrators were a **"Group of individuals"**, enter an estimated Age Group. If the range of ages does not fit the given fields, a primary perpetrator can be identified and an **Age Group** selected. Age group can be estimated.
Alleged Perpetrator Main Occupation	• If the main occupation does not appear, mark **"Other"**.
Alleged Perpetrator Occupation	• Enter an occupation to provide a more specific response

1.5 | Incident location type vs. Incident location

Incident Location Type refers to a category of locations relevant at field, sub-office or national level to help detect possible trends of where incidents of SGBV may be taking place. This field must contain information for a new SGBV case to be created.

In order to save additional, more specific **Incident Location** details (country of incident, address if known, etc.).

Information relevant to the operation:

Field Name	Action required
Incident Location Type	• Select **"Survivor's Residence"** if the survivor and perpetrator share the same residence.
Incident Location	• Create and save an SGBV case. • Create an **SGBV Incident** within the SGBV case. • Add details under **Incident Location**.
Country	• Record the name of the Country of Incident

1.6 | How to record consent

The areas to record consent related to an SGBV case are divided into two parts in proGres v4. The first part related to biometric information is located within the Registration module and the second part related to the SGBV case is within the SGBV module.

Field Name	Action required
PoC agrees to share this information	• Select **"No"** if the survivor does not wish to have information about the SGBV case shared with anyone besides the case worker. • Select **"Yes"** after obtaining the informed consent of a survivor (see Note below).
Person not capable of providing consent	• Select **"No"** for adult; • Select **"Yes"** for a child or a person with a mental disability or other condition who is unable to make thier own decisions. Additional mandatory fields will appear.

***Note:** A paper Consent Form, agreed by all organizations, should be signed by the survivor after receiving their **INFORMED CONSENT** and stored in a locking file cabinet separate from any notes or details on the SGBV case. For more information on Informed Consent, see SGBV Case Management Guidelines.*

1.7 | Referral of an SGBV Case

N.B. Be careful not to include sensitive information in the Referrals entity, noting that referrals are widely visible in proGres. If you would like to track more sensitive information about a referral service, you can create an intervention record and enter the details there.

It is important to note that INTERNAL means only UNHCR.

A due date can be recorded to indicate to a proGres user (UNHCR or partner staff) receiving the referral within proGres when the action requested in the referral should be completed. A due date can also act as a record and reminder to the SGBV case manager to follow up on the pending action if the referral is to a non-proGres user.

Field Name	Action required
Due Date	• Enter a referral due date corresponding to the **Priority level** of the case and the priority of the action requested.

1.7.1 INTERNAL REFERRALS

Information relevant to the operation

- **Psychosocial support or counseling (UNHCR)**
  - Service type: Psycho-social assistance
  - Referral type: internal
  - Referred to: proGres User
  - Service Provider: department or unit
  - Recommended action: case management
- **Legal/protection counseling (UNHCR)**
  - Service type: Legal/protection counseling
  - Referral type: internal
  - Referred to: proGres User
  - Service Provider: department or unit
  - Recommended action: legal assistance and counselling on access to justice
- **Livelihoods services (UNHCR)**
  - Service type: Livelihoods
  - Referral type: internal
  - Referred to: proGres User
  - Service Provider: department or unit
  - Recommended action: provision of livelihoods counseling and information
- **SGBV cash assistance (UNHCR)**
  - Service type: Cash assistance
  - Referral type: internal
  - Referred to: proGres User
  - Service Provider: department or unit
  - Recommended action: provision of CBI counseling

1.7.2 EXTERNAL REFERRALS

An external referral of an SGBV case describes a referral by UNHCR to another entity for counseling, assistance or service provision. The entity may be a proGres v4 user (for example, an implementing partner) or a non-proGres v4 user (for example, an operational partner or government agency).

1.7.2.1 proGres v4 users

Information relevant to the operation

- **Psychosocial support or counseling (implementing partner)**
  - Service type: Psycho-social assistance
  - Referral type: external
  - Referred to: proGres User
  - Service Provider: search for and select code of partner
  - Recommended action:assessment, action plan and follow up support
- **Livelihoods services (implementing partner)**
  - Service type: Livelihoods
  - Referral type: external
  - Referred to: proGres User
  - Service Provider: search for and select code of partner
  - Recommended action: provision of livelihoods counseling and information

1.7.2.2 Non-proGres v4 users

Information relevant to the operation

- **Psychosocial support or counselling**
  - Service type: Psycho-social assistance
  - Referral type: external
  - Referred to: Non-proGres User
  - Service Provider: search for and select code of partner
  - Recommended action: assessment, action plan and follow up support
- **Legal assistance**
  - Service type: Legal aid
  - Referral type: external
  - Referred to: Non-proGres User
  - Service Provider: search for and select code of partner
  - Recommended action: legal assistance and counselling on access to justice
- **Livelihoods services**
  - Service type: Livelihoods
  - Referral type: external
  - Referred to: Non-proGres User
  - Service Provider: search for and select code of partner
  - Recommended action: provision of livelihoods counselling and information

- **Temporary safe shelter**
  - o Service type: Accommodation
  - o Referral type: external
  - o Referred to: Non-proGres User
  - o Service Provider: search for and select code of partner
  - o Recommended action: provision of temporary safe shelter for case and "X" number of dependents
- **Long term safe shelter**
  - o Service type: Shelter assistance
  - o Referral type: external
  - o Referred to: Non-proGres User
  - o Service Provider: search for and select code of partner
  - o Recommended action: counseling and assistance with locating long term safe shelter for case and "X" number of dependents

Additional procedures will be created for transfer of cases.

1.8 | Case Closure

Cases can be closed when a survivor's needs are met and they no longer need services (ideally agreed by both case manager and survivor); when the survivor wants to close the case; if a survivor is not contactable for 30 days or more or is relocated to another area.

Make sure to have checked the statuses of all of the associated Incidents, Assessments, Interventions and Referrals – all of these should be 'closed' or 'completed'.

If the case is closed because the survivor's needs are met, an Assessment should have been completed, reflecting this and recommending closure prior to changing the process status. If a survivor wishes to close, disappears, or is relocated, the case can be closed, indicating the reason, adding reasons / details in the comments section, or completing an Assessment with additional information.

To set the Process Status of a SGBV Case or multiple SGBV Cases to Close follow these steps:

1. Login as a SGBV user.
2. Navigate to the SGBV module and select SGBV Cases. A list of SGBV Cases gets displayed.
3. Select SGBV cases with process status Active, Hold, Inactive or Erroneous.
4. From the ribbon, click on Change Process Status and select Close. A dialogue box gets displayed.
5. The process status date defaults to today's date. The Process status date cannot be blank and cannot be in the future. The Process status change Reason cannot be blank and can be set to one of the following values:

a. Resolved / Completed
b. Durable solution
c. No further action
d. Death
e. Not reachable
f. Withdrawn
g. Relocation / transfer
h. Other

Should there be any Incidents, SGBV Assessments or Interventions with [Process Status] NOT Closed or Erroneous associated with the Case then the following warning message is displayed to the user: ("At least one active Incident, Assessment, or Intervention is associated with the selected Case(s). If you proceed, the Process Status of all these records will be changed").

Fill in an appropriate value for the process status date and fill in all the mandatory fields. Complete the dialogue. The process status of the SGBV cases is set to Closed.

6. The process status change reason is set to the value entered by the user. The process status date is set to the value entered by the user.

For all associated Incidents, Interventions, SGBV Assessments, Alleged Perpetrator records or Incident Location records where Process Status is NOT Closed or Erroneous the changes are as follows:

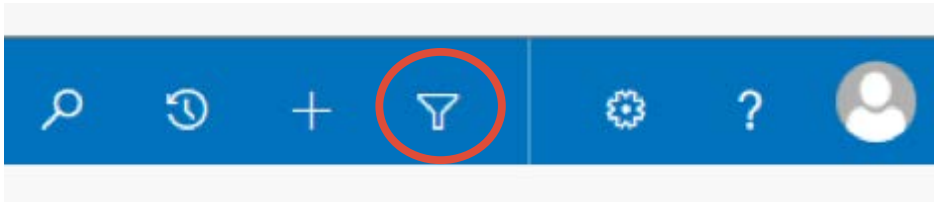
a. [Process Status] is set to Closed.
b. [Process Status Date] is set to SGBV Case's [Process Status Date]
c. [Process Status Change Reason] is set to:
   1. SGBV case's [Process Status Change Reason] for associated Incidents.
   2. Blank for associated Interventions or SGBV Assessments

The SGBV case records remain or become non-editable.

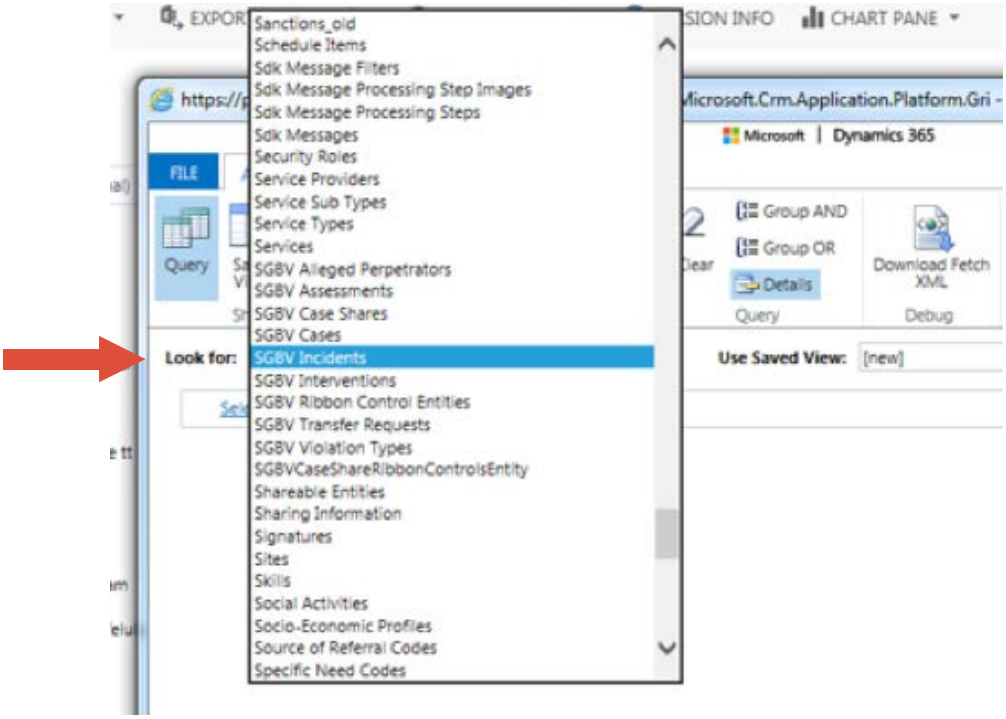
1.9 | Create a VIEW of SGBV Incidents by Type

It is possible to create VIEWS in proGres v4 for various purposes. For example, a VIEW can be created to help the user keep track of cases recorded and pending actions. Standard VIEWS can be created and shared by managers with users in their team or between UNHCR and partners. One example of a useful VIEW that can be created is SGBV Incidents by Type (Incident Sub-Type).

1. Click on the **Filter Icon** in the Ribbon to open the Advanced Find window;

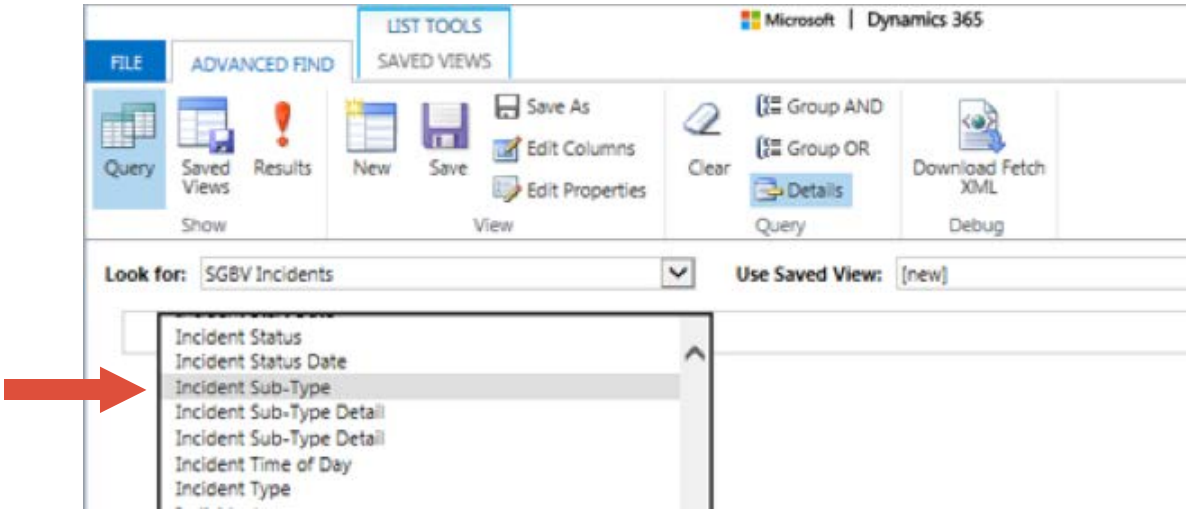


2. Locate Look for: and select **"SGBV incidents"** from the pulldown menu;

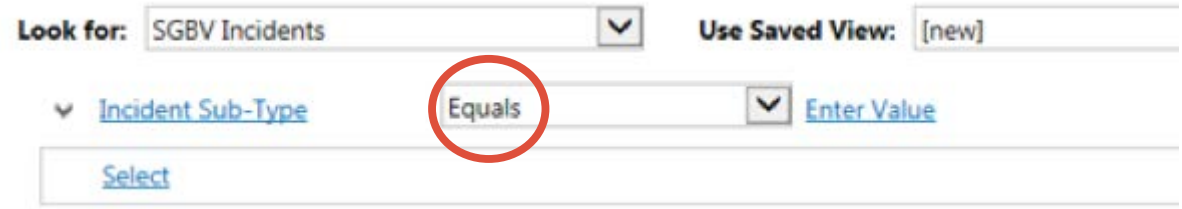


3. Notice that **Use Saved** View reads: [new]. Click on **Select** under SGBV Incidents.

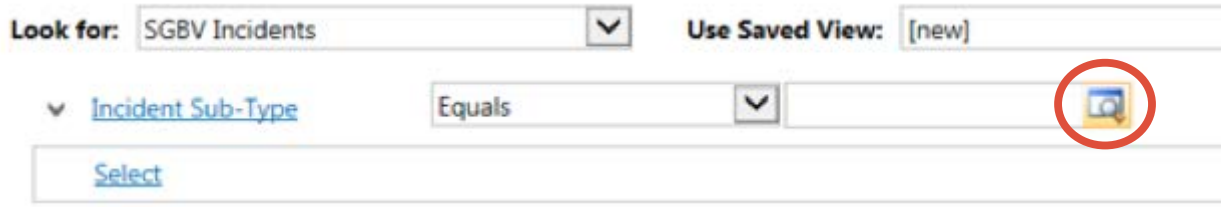
4. Select **"Incident Sub-Type"** from the pulldown menu.



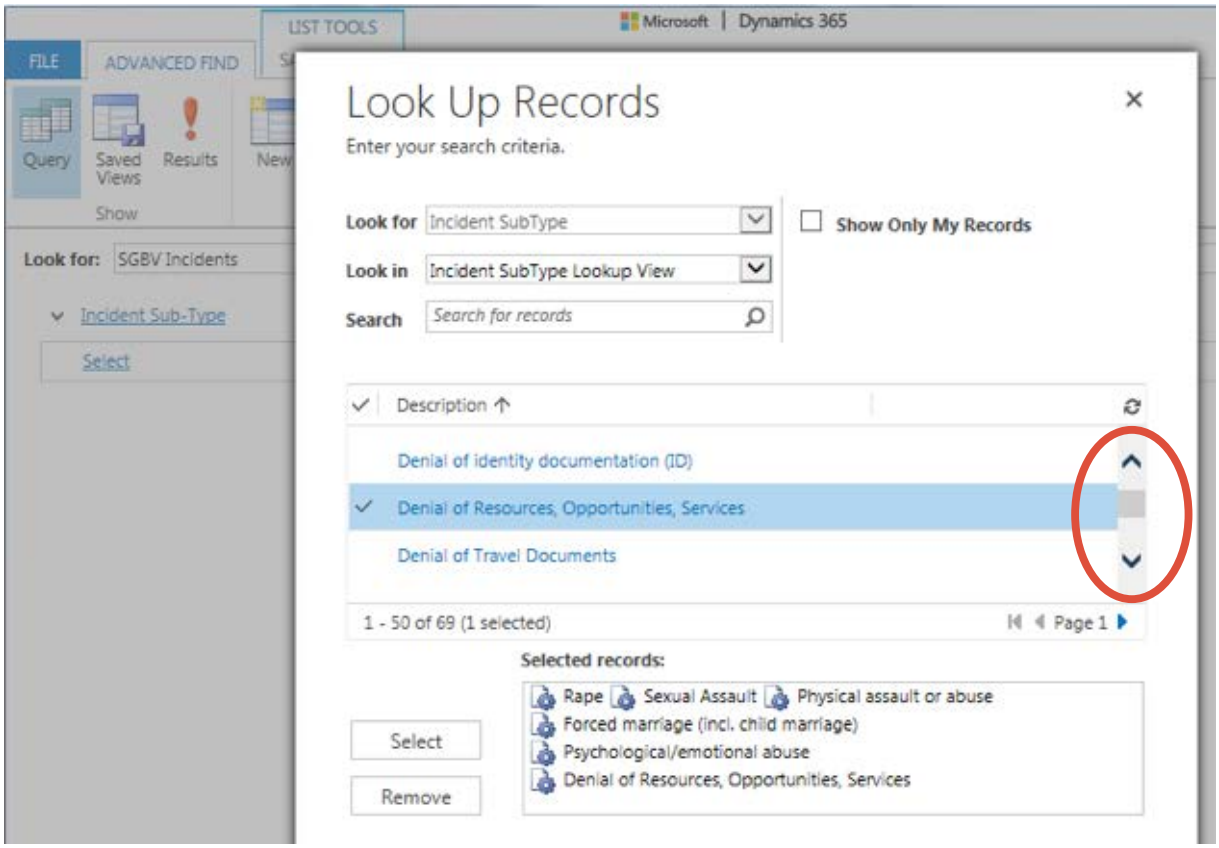
5. Select **Equals** in the pulldown menu to the right of Incident Sub-Type.



6. To the right of **Equals**, roll over **Enter Value** and click on the search icon that appears to the right of the text box.

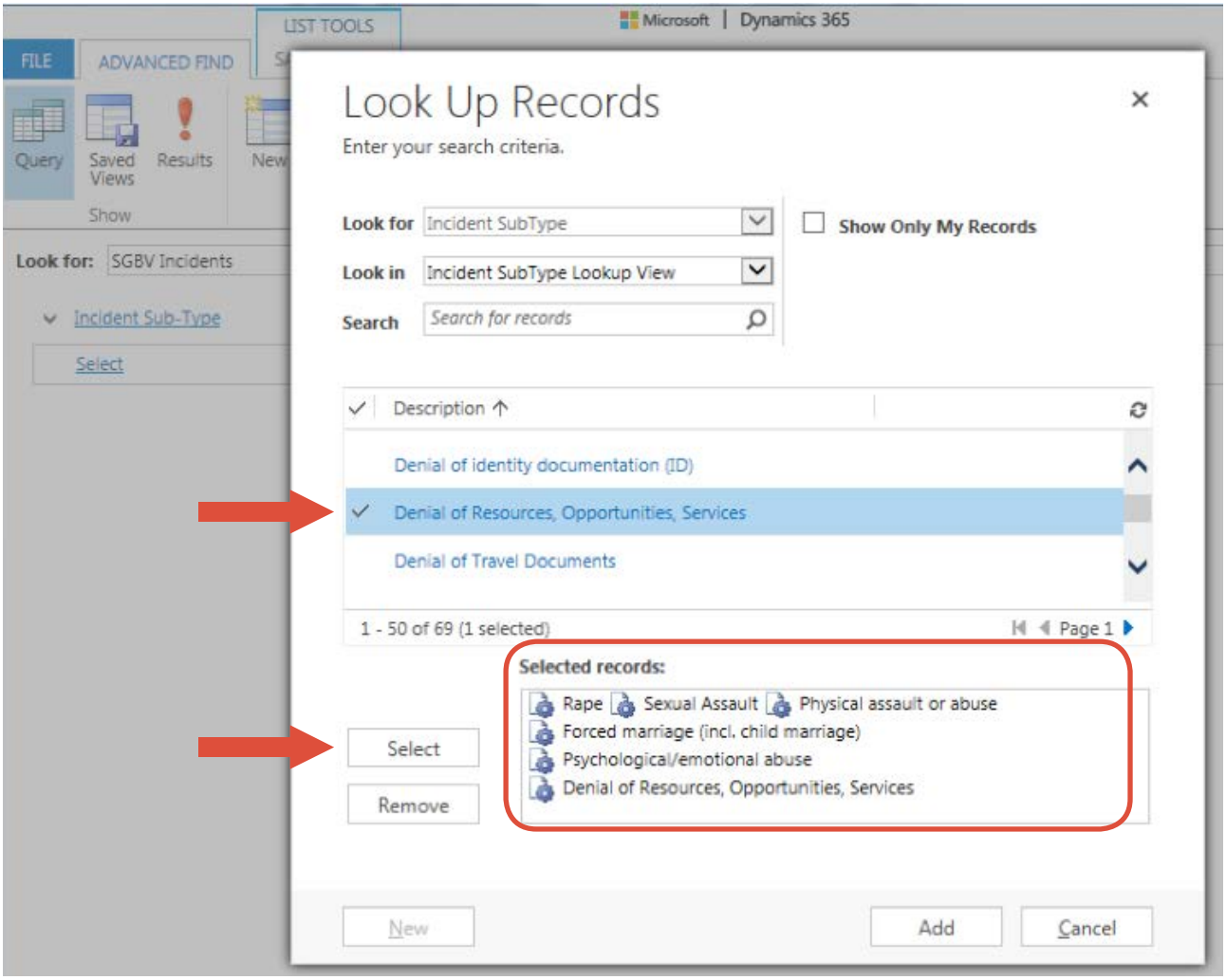


7. Use the **scroll bar** and the **page advance button** in the **Look Up Records** window to locate the following 6 types of SGBV:
   a. Rape
   b. Sexual Assault
   c. Physical assault or abuse
   d. Forced marriage (incl. child marriage)
   e. Denial of Resources, Opportunities, Services
   f. Psychological/emotional abuse

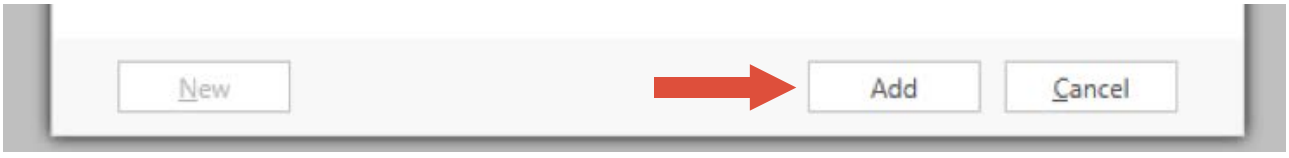


8. Highlight each type of SGBV one at a time and click the **Select button** to add them to the box called **Selected records**.

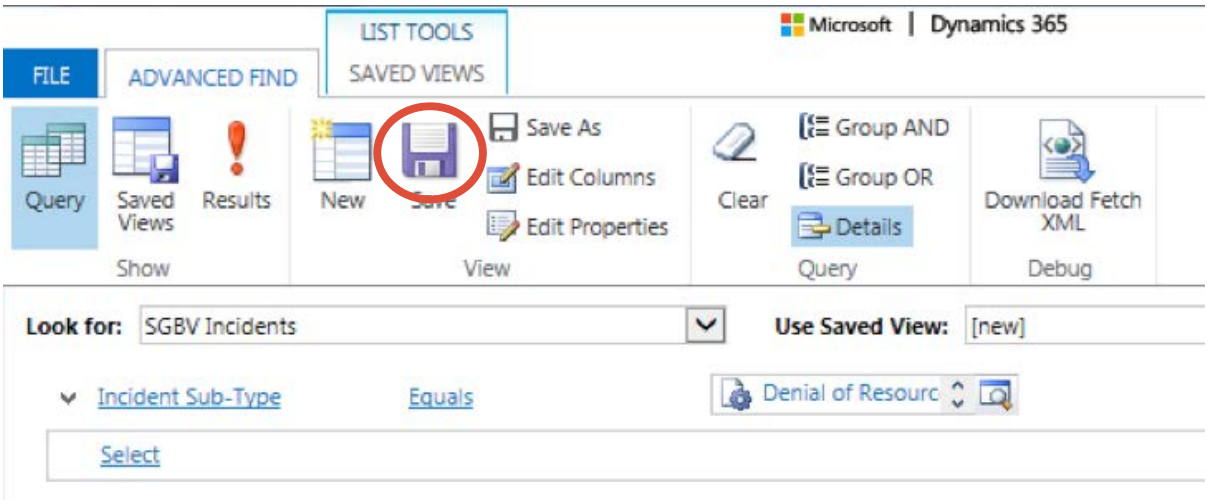
   ***Note:** Clicking on the term in blue will open a new window with an explanation of the term. Instead, click on the blue area highlighted around the term.*



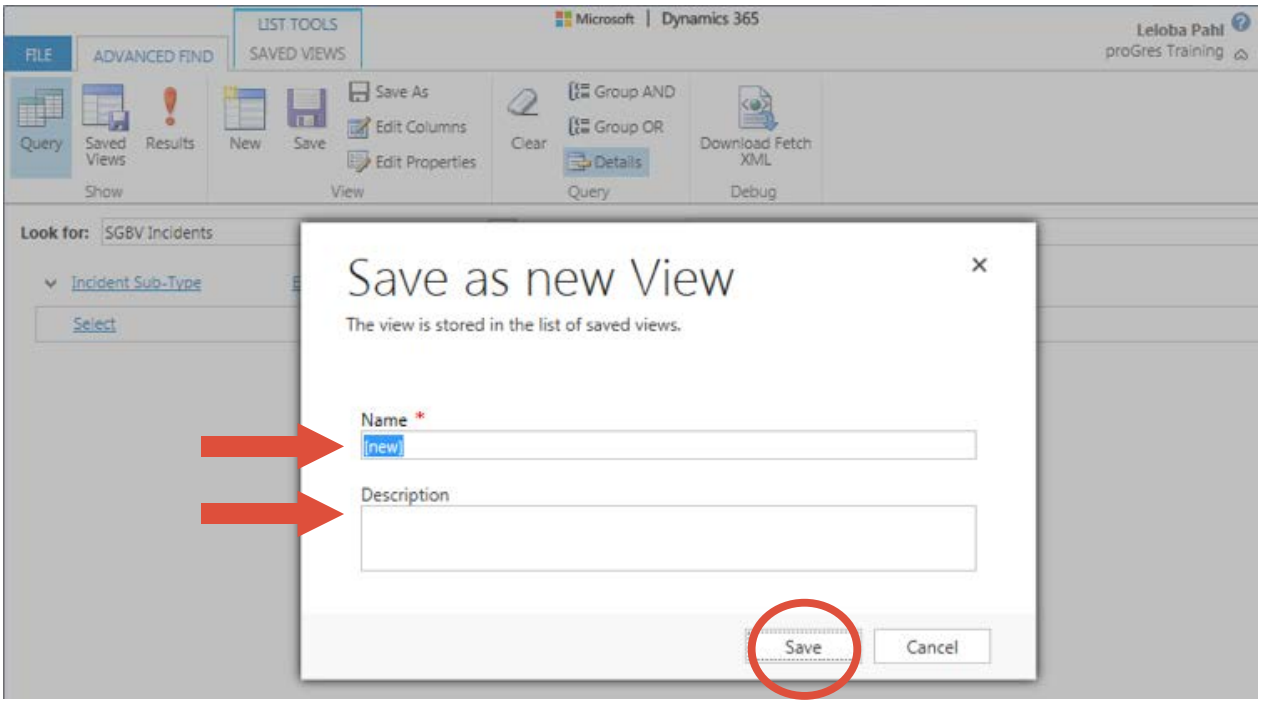
9. Click **Add** after all 6 types of SGBV appear in the Selected records box.



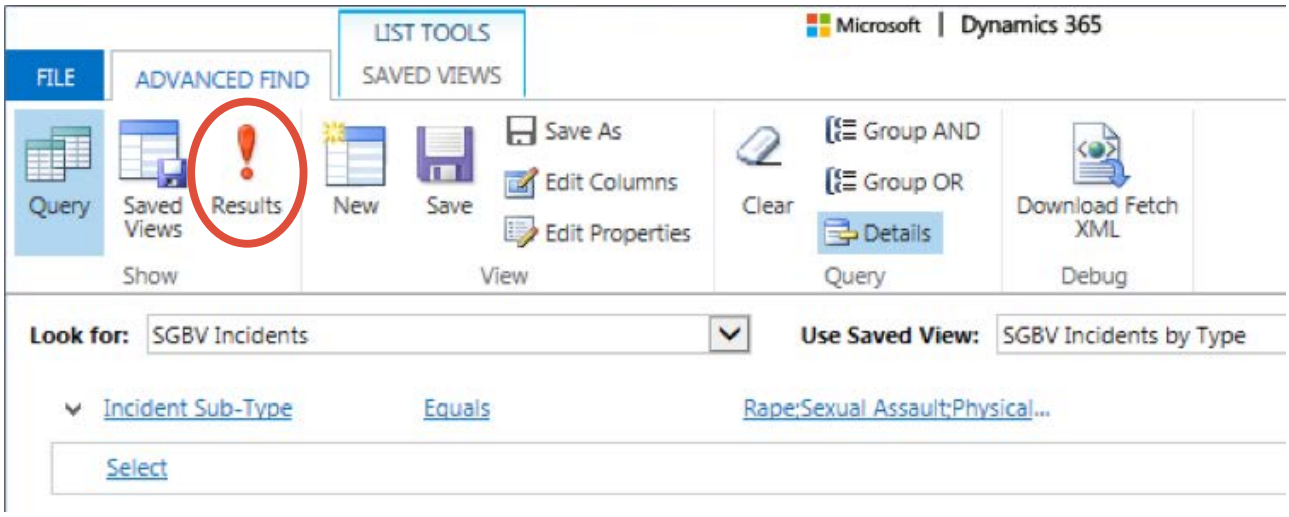
10. Click on the **Save** button (disk icon) to save the view.



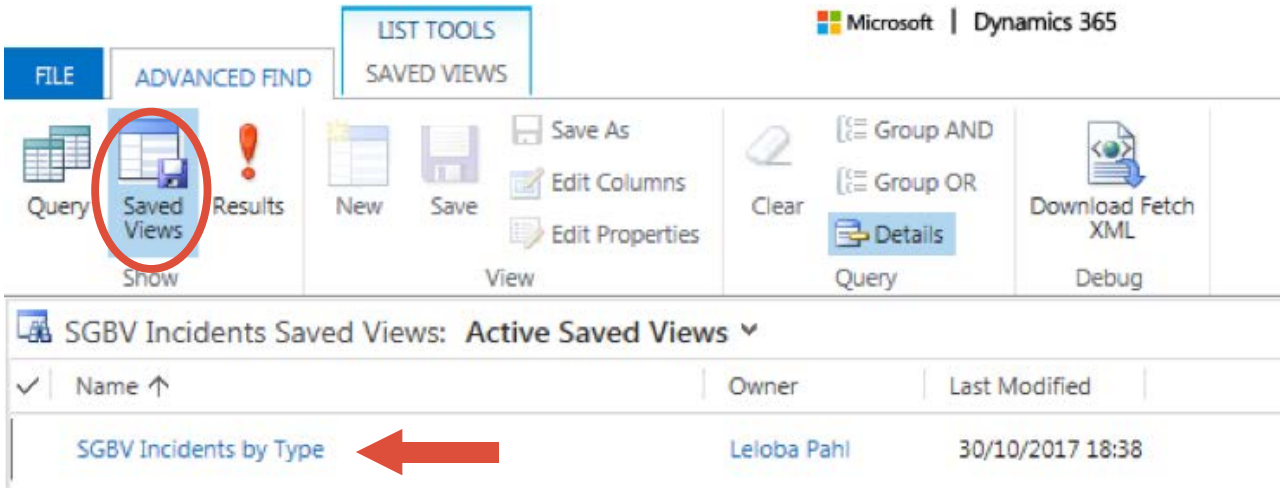
11. Enter the name for this view: **"SGBV Incidents by Type"** and enter a short description: **"This view shows SGBV incidents classified under the 6 types of SGBV: Rape; Sexual assault; Physical assault; Forced marriage; Denial of Resources, Opportunities, Services; and Psychological/emotional abuse."** Click Save.



12. Click on the **Results** button to view an updated list of SGBV Incidents by Type.



13. Click on **Saved Views** to see the view **SGBV Incidents by Type** and all other newly created views.



CONSENT FOR RELEASE OF INFORMATION

Incident ID	Client Code

CONFIDENTIAL
Consent for Release of Information[1]

This form should be read to the survivor or guardian in her first language. It should be clearly explained to the survivor that she / he can choose any or none of the options listed.

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

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

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

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

   I would like information released to the following:
   (Tick all that appy, and specify name, facility and agency/organization as applicable)

Yes	No	
☐	☐	Security Services (specify): ----------
☐	☐	Psychosocial Services (specify): ----------
☐	☐	Health/Medical Services (specify):----------
☐	☐	Safe House / Shelter (specify): ----------
☐	☐	Legal Assistance Services (specify): ----------
☐	☐	Livelihoods Services (specify): ----------
☐	☐	Other (specify type of service, name, and agency): ----------

1. Authorization to be marked by client: (or parent/guardian if client is under 18) ☐ **Yes** ☐ **No**

1. Reprinted from GBVIMS Consent for Release of Information Form Version 2 (Finalized October 2010) *http://gbvims.com/wp/wp-content/uploads/IntakeandConsentForm_Feb20112.pdf*

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

2. Authorization to be marked by client: (or parent/guardian if client is under 18) ☐ **Yes** ☐ **No**

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

Caseworker Code: ---------- **Date:** ----------

INFORMATION FOR CASE MANAGEMENT:
(Optional delete if not necessary)

Client's Name: ----------

Name of Caregiver (if client is a child): ----------

Contact Number: ----------

Address: ----------

(Write questions for Survivor Code Here)

SGBV INCIDENT CLASSIFICATION TOOL[1]

The humanitarian community has not been able to collect, classify and analyze Sexual and Gender-Based Violence (SGBV) -related information in a way that produces comparable statistics. At present, it is nearly impossible to compile and analyze data across programs and field sites. This cannot be solved without taking a new approach to how types of GBV are classified. To address this problem, the UN High Commissioner for Refugees (UNHCR), the UN Population Fund (UNFPA), and the International Rescue Committee (IRC) have developed a new SGBV classification tool strictly for the purposes of standardizing SGBV data collection across SGBV service providers.

The criteria used to generate the classification tool's six types of SGBV were:
- Universally-recognized forms of sexual and gender-based violence
- Mutually exclusive (they do not overlap)
- Focused on the specific act of violence; separate from the motivation behind it or the context in which it was perpetrated

Each of the definitions below refers to the concept of **consent**.[2] Consent is when a person makes an informed choice to agree freely and voluntarily to do something. 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, or a promise made to the person to provide a benefit.

Six Core Types of SGBV.[3] The six core SGBV types were created for data collection and statistical analysis of SGBV.[4] They should be used only in reference to SGBV even though some may be applicable to other forms of violence which are not gender-based.

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1. The SGBV Classification Tool was developed as part of the GBVIMS project initiated in 2006 by OCHA, UNHCR, and the IRC. The GBVIMS global team has counted on technical guidance from the Inter-Agency Standing Committee's (IASC) Sub-Working Group on Gender and Humanitarian Action, throughout the project.
2. Many laws set an age of consent. These legal parameters do not apply to the SGBV types proposed for this system. For the purposes of the GBVIMS a child is any survivor who was under 18 at the time when the incident occurred.
3. Case definitions used in the context of SGBV programming are not necessarily the legal definitions used in national laws and policies. Many forms of SGBV may not be considered crimes, and legal definitions and terms vary greatly across countries and regions.
4. Several resources were considered when preparing this document. Most importantly, the IASC Guidelines for Gender-based Violence Interventions in Humanitarian Setting, and Sexual and Gender-Based Violence against Refugees, Returnees, and Internally Displaced Persons, Guidelines for Prevention and Response (UNHCR)

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. FGM/C 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/C.*
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, 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. Reports of general poverty should not be recorded.
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, harassment, unwanted attention, remarks, gestures or written words of a sexual and/ or menacing nature, destruction of cherished things, etc.

EXPLANATION:

Any incident involving SGBV can often involve more than one form of violence (i.e. a woman who is raped, beaten and psychologically abused during the course of an incident). **This system can only capture one type of SGBV per incident.** To ensure valid and statistically comparable data, all those using the same system must use the same approach to determine how to classify a given incident based upon the type of SGBV it involved. **The types of SGBV are listed in a specific order to ensure statistically comparable data.**[5] The instructions below allow us to use a process of elimination to determine the most specific incident type to use in classifying a reported incident.

5. The order is NOT intended to express an implied 'value' of the SGBV types (i.e. rape is worse than forced marriage).

INSTRUCTIONS FOR USING THE SGBV CLASSIFICATION TOOL

To determine the appropriate SGBV classification for the incident described to you by the survivor, ask yourself the following questions in their given order.

If the answer to the question is "No" based upon the description of the reported incident, continue down the list to the next question. Stop, at the first question that can be answered "Yes" based upon the description of the reported incident. When you reach a question that's answer is "Yes" is for the description of the reported incident. The corresponding SGBV type listed next to this question is what should be used to classify the SGBV involved in this incident.[6]

The GBVIMS only records incidents reported directly by the survivor (or by the survivor's guardian if the survivor is a child or unable to report due to a disability) in the context of receiving services. Thus any incidents in which the victim has died prior to the report, are excluded from data being recorded for the GBVIMS.[7]

1. Did the reported incident involve **penetration**?
   If yes ▸ classify the SGBV as **"Rape"**.
   If no ▸ proceed to the next SGBV type on the list.
2. Did the reported incident involve **unwanted sexual contact**?
   If yes ▸ classify the SGBV as **"Sexual Assault".**
   If no ▸ proceed to the next SGBV type on the list.
3. Did the reported incident involve **physical assault**?
   If yes ▸ classify the SGBV as **"Physical Assault"**.
   If no ▸ proceed to the next SGBV type on the list.
4. Was the incident an act of **forced marriage**?
   If yes ▸ classify the SGBV as **"Forced Marriage"**.
   If no ▸ proceed to the next SGBV type on the list.
5. Did the reported incident involve the **denial of resources, opportunities or services**?
   If yes ▸ classify the SGBV as **"Denial of Resources, Opportunities, or Services"**.
   If no ▸ proceed to the next SGBV type on the list.
6. Did the reported incident involve **psychological/emotional abuse**?
   If yes ▸ classify the SGBV as **"Psychological / Emotional Abuse"**.
   If no ▸ proceed to the next SGBV type on the list.
7. Did the reported incident involve **SGBV**?
   If yes ▸ Start over at number 1 and try again to reclassify the type of SGBV *(If you have tried to classify the SGBV multiple times ask your supervisor or GBVIMS focal point for support)*
   If no ▸ classify the violence as **"Non-SGBV"**

Service providers are encouraged to continue to capture all the information of reported incidents needed for service provision as described by their clients in their case notes. The type of information appropriate to collect and record may differ between services.

6. For example, within this system, an incident where a woman reports having been beaten by her husband and also forced to have sex with him the SGBV would be classified as "rape".
7. This rule was established to avoid 3rd party reports outside of the context of service delivery.

GUIDANCE ON THE USE OF STANDARDIZED SPECIFIC NEEDS CODE

Note:
Multiple needs codes may be used per individual.[1]
Those with a tick mark in front of the codes are specific needs that can be identified with minimal training. They can be collected with very little complication during mass registration exercises.

	Code	Description	Definition
	CR	Child at risk[2]	Person below the age of 18[3] who is at risk due to his/her age, dependency and/or immaturity. Note: If the risk relates only to the unaccompanied or separated status, use the SC category ("unaccompanied and separated child"). For Children who are at risk of or are exposed to SGBV or Torture should use the SV and TR codes.
√	CR-CP	Child parent	Parent below the age of 18.
√	CR-CS (former CR-MS)	Child spouse	Person below the age of 18 who is married. Note: For the purpose of application of the code CR-CS, the legality of the marriage in the country of residence or country of origin is not relevant. For instance, even if in a given country marriage is permitted by law at age 13, the child would still be considered a "child spouse". UNHCR defines "child marriage" as the union of two persons at least one of whom is under 18 years of age. Note: For marriage which was forced, use also SV-FM Forced marriage.
	CR-CC (former CR-CH)	Child carer	Person below the age of 18, who is not an unaccompanied child and who has assumed responsibility as head of household. For example, a child who still lives with parents, but have taken on the role of caring for them (and possible siblings) due to the fact that the parents are ill, disabled, etc. Note: For unaccompanied child who is the head of household, use SC-CH.
√	CR-TP	Teenage pregnancy	Pregnant girl below the age of 18 who may face social, protection and/or medical risks and, as a result, has specific support and assistance needs. The pregnancy may be the result of a pre-marital relation, rape, early or forced marriage. The girl may be under pressure to abort the child and/or lack access to safe abortion. Note: A girl who subsequently, during the period of lactation, needs to be enrolled in a targeted supplementary feeding and nutrition programme, for medical or other reasons, should be recorded as "Women at risk – Lactation (WR-LC)" See also: SM-DP – Difficult pregnancy

[1] At registration, an individual may present one or more vulnerabilities. Registration staff should code each specific need separately, seeking the most appropriate category but avoid multiple vulnerability codes for the same characteristic. For example: a single older person grandparent head of household should be coded ER-MC only, not ER-MC and SP-GP.

[2] See ExCom, *Conclusion on Children at Risk*, 5 October 2007, No. 107 (LVIII) – 2007, http://www.unhcr.org/refworld/docid/471897232.html.

[3] The Convention on the Rights of the Child (CRC) defines, in Article 1, a "child" as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". See: http://www.unhcr.org/refworld/docid/3ae6b38f0.html.

** Extracted from UNHCR Guidance on the Use of Standardize Specific Needs Codes, dates 19 June 2009*

Code	Description	Definition
CR-LW	Child engaged in worst forms of child labour	Person below the age of 18 who is engaged in the worst forms of child labour, which include all forms of slavery or practices similar slavery (such as the sale and trafficking of children, debt bondage and serfdom and forced or compulsory labour, including forced or compulsory recruitment of children for use in armed conflict); the use, procuring or offering of a child for prostitution, for the production of pornography or for pornographic performances; the use, procuring or offering of a child for illicit activities, in particular for the production and trafficking of drugs as defined in the relevant international treaties; work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children.[4]
CR-LO	Child engaged in other forms of child labour	Person below the age of 18 who is engaged in forms of child labour other than the worst forms, such as work that is likely to be hazardous or to interfere with his/her education, or to be harmful to his/her health or physical, mental, spiritual, moral or social development.[5] UNICEF defines child labour as work that exceeds a minimum number of hours, depending on the age of a child and on the type of work. Such work is considered harmful to the child: ages 5-11: at least one hour of economic labour or 28 hours of domestic labour per week; ages 12-14: at least 14 hour of economic labour or 28 hours of domestic labour per week; ages 15-17: at least 43 hours of economic or domestic work per week.[6]
CR-NE	Child at risk of not attending school	Person below the age of 18 who is unable or unwilling to attend school, or is at heightened risk of interruption or discontinuation of his/her education.
CR-SE	Child with special education needs	Person below the age of 18 who has physical, mental, sensory or intellectual impairments or who otherwise requires special attention whether in general or through specialized education. Note: See also: DS, SC-IC.
CR-AF (former CR-CC)	Child associated with armed forces or groups	Person below the age of 18 who is or has been recruited into, or used by, an armed force or armed group in any capacity, including as fighter, cook, porter, messenger, spy, or for sexual purposes or forced marriage. It does not only refer to a child who is taking or has taken a direct part in hostilities.[7]
CR-CL	Child in conflict with the law	Person below the age of 18 who is, or has been, charged or convicted for an infringement of the law.
SC	**Unaccompanied or separated child**	**Person below the age of 18 who is currently not under the care of either parent or other legal or customary primary caregiver.**
SC-SC	Separated child	Person below the age of 18 who is separated from both parents and his/her legal or customary primary caregiver, but not necessarily from other relatives. This may, therefore, include boys and girls accompanied by other adult family members.[8]

[4] See International Labour Organization (ILO), *Worst Forms of Child Labour Convention*, No. 182, http://www.unhcr.org/refworld/docid/3ddb6e0c4.htm

[5] See article 32 CRC.

[6] See ILO, *Minimum Age Convention*, No. 138, http://www.unhcr.org/refworld/docid/421216a34.html, and UNICEF's definition of child labour: http://www.unicef.org/protection/index_childlabour.html.

[7] UNICEF, *The Paris Principles. Principles and Guidelines on Children Associated With Armed Forces or Armed Groups*, February 2007, Definition 2.1, p. 7, http://www.unhcr.org/refworld/docid/465198442.html.

[8] *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*, January 2004, p. 13, http://www.unhcr.org/refworld/docid/4113abc14.html.

	Code	Description	Definition
	SC-UC (former SC-UM)	Unaccompanied child	Person below the age of 18 who has been separated from both parents and other relatives and is not being cared for by an adult who, by law or custom, is responsible for doing so. [9]
√	SC-CH	Child-headed household	A household headed by a person below the age of 18 who is left without any adult to care for him/her (i.e. an unaccompanied child) and therefore assumes responsibility of a head of household[10]
	SC-IC (former SC-UC)	Child in institutional care	Person below the age of 18 who has been placed under institutional care, such as care often operated by a religious institution, governmental body, non-governmental organization or specialized agency to meet the basic needs of the child. These children may have been orphaned, unaccompanied, separated, from destitute families, abused or abandoned. Institutional care should be viewed as a last resort.
	SC-FC (former SC-UF)	Child in foster care	Person below the age of 18 who is cared for in a household outside his/her family. Foster care is usually understood to be a temporary arrangement and in most cases, the birth parents retain their parental rights and responsibilities. Foster care includes a variety of arrangements as follows: - traditional or informal foster care, where the child is taken into the care of a family or other household that may or may not be related to the child's family. No third party is involved in these arrangements, although they may be endorsed or supported by the local community and involve clear obligations and entitlements; - spontaneous foster care, where a family or other household takes into its care a child without any prior arrangement. This is a frequent occurrence during emergencies and may involve families from a different community in the case of refugee children; - arranged foster care, where a child is taken into the care of a family as part of an arrangement made by a third party, usually an agency involved in social welfare such as a government department, a religious organization, a national or international non-governmental organization, or in certain cases UNHCR.
	WR	**Woman at risk[11]**	**Woman of 18 years old or above, who is at risk because of her gender, such as single mothers or caregivers, single women, widows, older women, women with disabilities and survivors of violence.** **Note: For girls under the age of 18, use a code from the CR ("Child at risk") or SC ("Unaccompanied or separated child") categories instead wherever appropriate.** **Note: This code should be used in conjunction with other specific codes.**
	WR-WR	Woman at risk	Woman of 18 years old or above, who is at risk because of her gender, such as single mothers or caregivers, single women, widows, older women, women with disabilities and survivors of violence. This category takes into consideration the presence and severity of a range of risk factors. These factors in the wider protection environment can result from security problems threatening or exposing women to sexual and gender-based violence (SGBV) or other forms of violence; problems accessing and enjoying assistance and services; the position of women in society leading to inequalities; legal systems and protection mechanisms that do not adequately respect protect and fulfil women's rights; and the absence of solutions. Individual risk factors which threaten the rights of women can result from civil

[9] *Idem*.
[10] *Idem,* p.50.
[11] See ExCom, *Conclusion on Women and Girls at Risk*, 6 October 2006, No. 105 (LVII) – 2006, http://www.unhcr.org/refworld/docid/45339d922.html.

Code		Description	Definition
			status or situation in society; previous exposure or risk of exposure, to SGBV and other forms of violence; and the need for specific health care or other support. Note: Use this code in conjunction with other specific needs categories, for example with female single parent (SP-PT); Victim/ survivor of SGBV in country of asylum (SV-VA) etc.
	WR-SF (former WR-HR)	Single woman at risk	Woman, without partner, unmarried, widowed, divorced or separated, and without children. Not all single women are at risk. This code should only be used where her single status has a resulting protection concern. Note: For a female single parent, use code SP-PT instead.
	WR-LC (former PG-LC)	Lactation	Woman or girl who, during the period of lactation, needs to be enrolled in a targeted supplementary feeding and nutrition programme, for medical or other reasons.
	ER	**Older person at risk**	**Person of 60 years old[12] or above, with specific need(s) in addition to his/her age. This includes single older persons and older couples. They may be the sole caregivers for others, suffer from health problems, have difficulty adjusting to their new environment, and/or otherwise lack psychological, physical, economic, social or other support from family members or others.**
√	ER-NF (former ER-UR)	Single older person	Person of 60 years old or above, without any family members in the country of asylum. The person may or may not receive some assistance from the community. Note: If the person cannot take care of him or herself, also record ER-FR.
√	ER-MC (former ER-MC & ER-SC)	Older person with children	Person of 60 years old or above who is the sole caregiver of children (below the age of 18), including his/her own children, grandchildren, other child relatives and non-related children. Note: See also SP-GP Single HR – grandparent.
	ER-FR	Older person unable to care for self	Person of 60 years old or above who is unable to care for him-/herself on a daily basis. This includes older persons who are physically weak, easily disoriented, without opportunity for economic or income-generating activities and who lacks psychological, physical, economic, social or other support from family members or others. Note: See also the DS category.
	SP	**Single parent or caregiver**	**Single person of 18 years or above with one or more dependants, including biological or non-biological children, or other dependants (such as an older person). The single parent/caregiver is both the primary income earner and/or caregiver.** **Note: In case of a single child parent household, use CR-CH instead.**
√	SP-PT	Single HR – parent	Single parent (male or female) household, with one or more biological children who are all under the age of 18.

[12] The UN-agreed cut-off is 60 years to refer to older persons, but exceptions can be made to the age requirement depending on the physical state of the individual. See, for example, World Health Organization, *Definition of an older or elderly person*, http://www.who.int/healthinfo/survey/ageingdefnolder/en/.

Code		Description	Definition
√	SP-GP	Single HR – grandparent	Single grandparent (grandmother or grandfather) household, with one or more grandchildren who are all under the age of 18. Note: In case of an older person, use ER-MC instead.
	SP-CG	Single HR – caregiver	Single caregiver (male or female) household, with one or more dependants other than biological children. These could be non-biological children, siblings or older parents requiring protection and care.
	DS	**Disability**	**Physical, mental, intellectual or sensory impairments from birth, or resulting from illness, infection, injury, trauma or old age. These may hinder full and effective participation in society on an equal basis with others.** **Note: Assessment of the patient to define whether the condition is moderate or severe would require a specialist/ qualified personnel.**
√	DS-BD	Visual impairment (including blindness)	Person who has a visual limitation from birth or resulting from illness, infection, injury or old age, which impacts daily life, may restrict independent movement, or require on-going treatment, special education or regular monitoring.
√	DS-DF	Hearing impairment (including deafness)	Person who has a hearing limitation from birth or resulting from illness, infection, injury or old age, which impacts daily life, and may require regular treatment, special education, monitoring or maintenance of artificial hearing device. The person may be able to communicate through sign language.
√	DS-PM	Physical disability – moderate	Person who has a physical impairment from birth or resulting from illness, injury, trauma or old age, which does not significantly limit the ability to function independently. This category may include mine victims and persons who lost fingers or limbs, which may be corrected with a prosthetic device. Note: See also the SM-MI code.
	DS-PS	Physical disability – severe	Person who has a physical impairment from birth or resulting from illness, injury, trauma or old age, which severely restricts movement, significantly limits the ability to function independently or pursue an occupation, and/or requires assistance from a caregiver. Note: See also the SM-MI code.
	DS-MM	Mental disability – moderate	Person who has a mental or intellectual impairment from birth or resulting from illness, injury, trauma or old age, which does not significantly limit the ability to function independently and interact, but may require special education, some monitoring and modest medication. Note: See also code SM-MI.
	DS-MS	Mental disability – severe	Person who has a mental or intellectual impairment from birth or resulting from illness, injury, trauma or old age, which significantly limits the ability to function independently or to pursue an occupation. It requires assistance from a caregiver, and may require medication and/or medical treatment.
	DS-SD	Speech impairment/disability	Person who is unable to speak clearly from birth or resulting from illness, injury, trauma or old age, which restricts or limits the ability to function independently, and may require speech therapy or medical intervention. The person may be able to communicate through sign language.

Code	Description	Definition
SM	**Serious medical condition**	**Serious medical condition that requires assistance, in terms of treatment or provision of nutritional and non-food items, in the country of asylum.** **Note: Exercise discretion and respect for confidentiality. In case of disability, use the above-mentioned DS codes ("disability"), as appropriate.** **Note: Assessment of the patient to define whether the condition is moderate or severe would require a specialist/ qualified personnel.**
SM-MI	Mental illness	Person who has a mental or psychological condition which impacts on daily functioning. This includes both persons formally diagnosed and persons suspected of having a mental illness. Characteristics of this category include obviously confused thinking; disorientation in time, place or person; marked inattention; obvious loss of contact with reality; clearly peculiar behaviour and severe withdrawal, anxiety, or depression such that daily functioning is affected. Mental illness also includes risk of harm to self or others. Note: A mental impairment is defined as "disability", when it is long-term and may hinder full and effective participation in society on an equal basis with others. When this is the case, the relevant disability codes (DS-MM and DS-MS) may also apply.
SM-MN	Malnutrition	Person who is either moderately or severely suffering from acute malnutrition as measured by "weight-for-height criteria", "mid-upper-arm circumference" (MUAC) or other recognized anthropometric (=body mass) measurements, and would benefit from supplementary (or therapeutic) feeding and nutrition programme[13].
SM-DP (former PG-HR)	Difficult pregnancy	Woman or girl who is diagnosed with a difficult pregnancy, which requires increased medical attention and additional assistance (such as supplementary feeding and nutrition programmes or special travel arrangements). This includes women pregnant as a result of rape, pregnant women without partner or a support network, pregnant women with HIV/AIDS, and malnourished pregnant women.
SM-CI	Chronic illness	Person who has a medical condition which requires long-term treatment and medication under the supervision of a physician. Such conditions include diabetes, respiratory illness, cancer, tuberculosis, HIV/AIDS and heart disease. Note: The specific condition or illness should not be recorded. In particular, note that a person living with HIV or AIDS should be assigned this code, but it should NOT be recorded that he/she has HIV or AIDS.
SM-CC	Critical medical condition	Person who has a life-threatening medical condition which requires immediate, life-saving intervention or treatment.
SM-OT	Other medical condition	Person who has a medical condition not otherwise mentioned, which has a serious impact on the ability to function independently. The condition requires caregiver support, but may not require hospitalization or continuous medical care.
SM-AD	Addiction	Person who has an alcohol, drugs or any other substance addiction that hinders, restricts or impacts his/her daily functioning. This may result in violent behaviour towards family members and/or inability to support family.

[13] See further: UNHCR, *Handbook for Emergencies*, Third edition, February 2007, Chapter 16, http://www.unhcr.org/refworld/docid/46a9e29a2.html.

Code	Description	Definition
FU	**Family unity**	**The right to family unity is inherent to the universal recognition of the family as the fundamental group unit of society and as a fundamental principle of refugee protection. The right to family unity may, depending on the circumstances, be infringed on when action is taken to separate an existing family unit, or when family members who already have been separated are not able or permitted to reunite.**
FU-TR (former LP-TC)	Tracing required	Person who needs to trace the whereabouts of family members or legal or customary caregivers, whose whereabouts are unknown but who are possibly in a particular location or in contact with an international agency (e.g. UNHCR or ICRC). The objective of tracing is family reunification, and is especially important if it involves children. Note: See also FU-FR, SC, ER
FU-FR (former LP-FR)	Family reunification required	Person of any age, male and female, who has family members known to be elsewhere in the country of asylum, in the country of origin or in a third country and with whom they need and want to be reunited in order to establish or re-establish long-term care. Normally, family reunification is required for members of the nuclear family such as spouse and children, or, where the applicant is a child, the parent(s). Family reunification may also be required for other family members where there is a significant social, emotional or economic dependency. Note: See also FU-FR, SC, ER
LP	**Specific legal and physical protection needs**	**Person with legal protection needs because of a threat to life, freedom or physical safety.**
LP-ND	No legal documentation	Person without legal documentation.
LP-BN	Unmet basic needs	Person who is unable to achieve, in spite of existing livelihood opportunities (whether formal or informal), a minimum standard of living, including access to food, clothing, sanitary material, housing/shelter, water, sanitation, and medical care.[14]
LP-NA	No acces to services	Person who is deprived of access to services, such as assistance distribution, health care, or legal services, which is otherwise available to the community and/or persons of concern. Note: This may be a consequence of other specific legal and physical protection needs such as marginalization from society or community (LP-MS); no legal documentation (LP-ND), unmet basic needs (LP-BN) etc. Use this code in conjunction with the other codes as appropriate.
LP-MM	Mixed marriage	Person who is married to a spouse of a different race, ethnicity, nationality or religion which exposes the family to physical risk or marginalization within their community in the country of asylum (camp or accommodation) and gives limited options for a durable solution (voluntary repatriation or local integration) in view of local political and social conditions[15].

[14] See further: UNHCR, *Handbook for Emergencies*, Third edition, February 2007, Section III, http://www.unhcr.org/refworld/docid/46a9e29a2.html; Sphere Project, *Sphere Handbook: Humanitarian Charter and Minimum Standards in Disaster Response*, 2004, http://www.unhcr.org/refworld/docid/3d64ad7b1.html.

[15] See further UNHCR, UNHCR, *Guidelines on International Protection No. 6: Religion-Based Refugee Claims under Article 1A(2) of the 1951 Convention and/or the 1967 Protocol relating to the Status of Refugees*, 28 April 2004, para 12, page 4-5, http://www.unhcr.org/refworld/docid/4090f9794.html; Universal Declaration of Human Rights Article 16, http://www.un.org/Overview/rights.html#a16.

Code	Description	Definition
LP-MD	Multiple displacements	Person who has been repeatedly displaced due to compelling external circumstances, either in the country of origin, a transitory country or in the country of asylum.
LP-RR (former LP-TR)	At risk of refoulement	Person who is at risk of being returned to the frontiers of territories where his/her life or freedom would be threatened, or where he/she is at risk of persecution for one of more grounds of the 1951 Refugee Convention, including interception, rejection at the frontier or indirect *refoulement*. Exceptionally, the principle of *non-refoulement* does not apply to a person when there are reasonable grounds for regarding him/her as a danger to the security and public safety of the country of asylum. This exception must, however, be interpreted very restrictively, subject to due process safeguards, and as a measure of last resort. In cases of risk of torture, no exceptions are permitted to the prohibition against *refoulement*.
LP-RD (former LP-TD)	At risk of removal	Person who is at risk of any form of removal other than refoulement, including deportation or expulsion by the government of a country of asylum to his/her country of origin or a third country. Note: In some cases, these persons are identified by the government of the country of asylum, and UNHCR is informed of pending removal.[16] If amounting to *refoulement*, LP-RR should be used.
LP-DA (former LP-DN & LP-DP)	Detained/held in country of asylum	Person who is, or has been, detained, imprisoned or otherwise in captivity or solitary confinement in the country of asylum, including a person who is or has been denied freedom of movement. Note: Specify the charges and location of detention in the comment box, if applicable. To determine, if this is at present or in the past, use 'from' – 'to' fields, if feasible. If the detention is related to a conviction, use LP-CR instead.
LP-DO	Detained/held in country of origin	Person who has been detained, imprisoned or otherwise in captivity or solitary confinement in the country of origin, including a person who is or has been denied freedom of movement. This also includes persons who have been detained informally by family or community members under the pretext of their own protection. Note: For formal detention, specify the charges and location of detention in the comment box, if applicable. To determine, when this happened, use 'from' – 'to' fields, if feasible. If the detention is related to a conviction, use LP-CR instead.
LP-DT	Detained/held elsewhere	Person who has been previously detained in a country other than the country of asylum or origin. Note: Specify the charges and detention details in the comment box. If detention is related to a conviction, use LP-CR instead.
LP-IH	In hiding	Person who is in hiding because he/she fears being identified or found. Note: When hiding is related to e.g. draft evasion, threat of honour crimes, forced marriage or other protection risks, in addition, use the relevant specific needs code.

[16] See further Article 32 of the 1951 *Convention relating to the Status of Refugees* ("1951 Refugee Convention") on the expulsion of refugees lawfully in the country of asylum. See: http://www.unhcr.org/refworld/docid/3be01b964.html.

Code	Description	Definition
LP-WP	Absence of witness protection	Person who is, or has been, a witness in legal proceedings and whose physical security and integrity is threatened due to a lack of effective witness protection.
LP-AN	Violence, abuse or neglect	Person of any age, who is at risk of physical and/or psychological violence, abuse, neglect or exploitation. The perpetrator may be any person, group or institution, including both state and non-state actors. Note: In cases of sexual or gender-based violence, use SV codes.
LP-RP (former LP-UP)	At risk due to profile	Person who is at risk of serious harm because of his/her profile in society. This may include prominent and/or vocal former government members, members of the political opposition, religious minorities, and members of civil society including human rights activists and business leaders. Due to their activities or public pronouncements in the country of origin or country of asylum which are controversial or encounter strong opposition, they are exposed to risks relating to their physical security and integrity. This may be evidenced by current or past detention, violence, or credible verbal or written threats to their physical safety.
LP-MS (former LP-ES)	Marginalized from society or community	Person who, due to his/her age, personal history, ethnicity, religion, nationality, social group, caste, illness, disability, gender, sexual orientation or other factors, is marginalized or exposed to discrimination, harassment, vilification, exclusion from participation and/or physical abuse by his/her society. Such marginalization or discrimination may be the result of prejudices, homophobia, xenophobia or other forms of intolerance.
LP-LS	Lack of durable solutions prospects	Person who lacks any prospects of local integration, voluntary repatriation and resettlement in the foreseeable future. Such person can not be expected to return to his/her country of origin within the foreseeable future, is not able to achieve minimal self-reliance and may require prolonged and individual assistance, and for whom resettlement has been pursued and has proven unobtainable.
LP-AP (former LP-VP)	Alleged perpetrator	Person who is alleged to directly have inflicted, supported or condoned violence or other abuse against a person or a group of persons. Perpetrators are often in a position of real or perceived power, decision-making and/or authority. This category includes suspected and charged perpetrators. Note: The accused individual is innocent until proven guilty. The confidentiality of the alleged perpetrator should be respected.
LP-CR	Criminal record	Person who has been convicted of a crime in the country of origin or the country of asylum.
LP-ST	Security threat to UNHCR/partner staff or others	Person who has made threats or shown aggression towards UNHCR staff, staff of partner organizations or others (including refugees). This person may appear unstable and may also be a threat to him-/herself.
LP-AF	Formerly associated with armed forces or groups	Person of 18 years old or above who has been formerly associated with armed forces or armed groups, and/or has directly or indirectly participated in any hostilities. Such person may be at risk of (excessive) punishment for draft evasion or desertion. Reintegration issues may be involved. Note: Persons falling under this category could be excludable from refugee status for committing war crimes; crimes against peace or crime against humanity etc.[17] For persons below the age of 18, use CR-AF.

[17] See further the exclusion clauses in Article 1F of the 1951 Refugee Convention.

Code	Description	Definition
TR	**Torture**	**Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.[18]** **Torture, therefore, includes four main elements: 1) severe physical or mental pain and suffering; 2) intent; 3) purpose; and 4) State involvement. Acts of torture may include, but are not limited to, beatings, kicks, burns, cuts, electric shock, suffocation, submersion, suspension, solitary confinement, toe/finger nail removal, and sexual assault/violence.** **Note: Certain forms of SGBV have been found to amount to torture, e.g. FGM and rape. For such cases, use the TR code plus the relevant SV code.** **Note: For those who are victims/ survivors of torture record only "TR".**
TR-PI	Psychological and/or physical impairment due to torture	Person who has a permanent or temporary psychological and/or physical impairment due to torture. Symptoms may include insomnia, lack of appetite, headaches, (acute) anxiety, nightmares, flashbacks, depression, suicidal tendencies, or behavioural problems. Note: Use this code when the person is in need of specialist rehabilitation.
TR-HO	Forced to egregious acts	Person who is or has been forced to inflict serious harm on self or others. This may include killing, mutilation, rape or other humiliating and extreme acts, such as eating or drinking bodily fluids or parts, or behaving as animals.
TR-WV	Witness of violence to other	Person who has witnessed physical violence against or killing of others (including family members or close friends).
SV	**SGBV**	**Any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to persons on the basis of their sex or gender, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life.** **It encompasses, but is not limited to: (i) physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (ii) physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; (iii) physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.**

[18] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 1984, Article 1, http://www.unhcr.org/refworld/docid/3b00f2224.html.

REGIONAL SGBV/ CHILD PROTECTION CASE MANAGEMENT-INFORMATION MANAGEMENT WORKSHOP

DAY 1:

INTRODUCTION TO SGBV/CHILD PROTECTION CASE MANAGEMENT

Note: Please follow the link to download the zip files for level 1 training tools, which includes PowerPoints and handouts. Training content and materials are based on and adapted from existing UNHCR and IASC guidelines and tools, some of which were used throughout the training. It is highly encouraged to adapt the training to your specific context and needs.

PPT Data Management in the Americas
PPT SGBV Core Concepts Handout Types of SGBV Handout SGBV Consequences Handout Questions about Sexual Violence
PPT Working with SGBV Survivors Handout Being Respectful Handout Essential Actions for Reducing Risk (of SGBV) Handout The Role of a Case Manager
PPT Introduction to SGBV Information Management Handout – Understanding the Challenges in SGBV IM

http://www.acnur.org/cgi-bin/texis/vtx/home/opendocAttachment.zip?COMID=5b6c6cdd4

DAY 2:

SGBV/CHILD PROTECTION CASE MANAGEMENT AND INTRODUCTION TO SGBV/CHILD PROTECTION INFORMATION MANAGEMENT

PPT SGBV Case Management: Coordination and Implementation
PPT Managing an SGBV Case Action Plan Template Handout SGBV Case Management Checklist Handout Intimate Partner Violence Risk Assessment Handout Key Messages to Share with IPV Survivors Handout Introduction and Engagement Role Play Case Conferencing- Kathya Role Play SGBV Case -Kathya
PPT Best Interests of the Child in SGBV Case Management BIA-BID Training Quiz
PPT Documenting SGBV and Child Protection Case Management Handout Protection Risks and Case Prioritization
PPT Self-Care Handout Self-care and Managing Stress

http://www.acnur.org/cgi-bin/texis/vtx/home/opendocAttachment.zip?COMID=5b6c6d414

DAY 3:
SGBV/CHILD PROTECTION INFORMATION MANAGEMENT

Handout UNHCR Data Protection Policy
PPT UNHCR Data Protection Policy 2015
PPT Identifying Data Points
PPT Introduction to SGBV and Child Protection Modules in proGres v4
PPT Referrals and Transfers of Cases in proGres v4

http://www.acnur.org/cgi-bin/texis/vtx/home/opendocAttachment.zip?COMID=5b6c6d784

PART 3:
ADDITIONAL RESOURCES

AGE, GENDER AND DIVERSITY POLICY

- UN High Commissioner for Refugees (UNHCR), *Policy on Age, Gender, and Diversity,* UNHCRIHCP/2018/1, 8 March 2018, available at: **http://www.unhcr.org/5aa13c0c7.pdf**

COMMUNITY BASED PROTECTION

- UN High Commissioner for Refugees (UNHCR), *A Community-based Approach in UNHCR Operations*, 01 January 2018, available at: **http://www.unhcr.org/publications/legal/47ed0e212/community-based-approach-unhcr-operations.html**
- UN High Commissioner for Refugees (UNHCR), UNHCR Manual on a Community Based Approach in UNHCR Operations, March 2008, available at: **http://www.refworld.org/docid/47da54722.html**
- UN High Commissioner for Refugees (UNHCR), UNHCR Tool for Participatory Assessment in Operations, May 2006, First edition, available at: **http://www.refworld.org/docid/462df4232.html**

SEXUAL AND GENDER-BASED VIOLENCE

- UN High Commissioner for Refugees (UNHCR), *Sexual Gender-Based Violence and Child Protection Glossary (Glosario Sobreprotección de la Infancia, Violencia Sexual y de Género y Terminología Relacionada)*, February 2018, available at: **http://www.acnur.org/fileadmin/scripts/doc.php?file=fileadmin/Documentos/BDL/2018/11638**
- UN High Commissioner for Refugees (UNHCR), *Recomendaciones para el uso de un Lenguaje Inclusivo de Género (Gender Inclusive Language Recommendations)*, February 2018, available at: **http://www.acnur.org/fileadmin/scripts/doc.php?file=fileadmin/Documentos/BDL/2018/11627**
- UN High Commissioner for Refugees (UNHCR), *SGBV Training Package*, October 2016, available at: **http://www.unhcr.org/publications/manuals/583577ed4/sgbv-prevention-response-training-package.html**

- UN High Commissioner for Refugees (UNHCR), *Action against Sexual and Gender-Based Violence: An Updated Strategy*, June 2011, available at: **http://www.refworld.org/docid/4e01ffeb2.html**

- Global Protection Cluster (GPC) and IASC (Inter-Agency Standing Committee), *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*, 2015, available at: **https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf**

- *Interagency gender-based violence case management guidelines*, 2017, available at: **http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf**

- UN High Commissioner for Refugees (UNHCR), Update on refugee women: promoting gender equality and eliminating sexual and gender-based violence, 4 June 2013, EC/64/SC/CRP.12, available at: **http://www.refworld.org/docid/5209f48d4.html**

- UN High Commissioner for Refugees (UNHCR), Sexual and Gender-Based Violence Against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response, May 2003, available at: **http://www.refworld.org/docid/3edcd0661.html**

CHILD PROTECTION

- UN High Commissioner for Refugees (UNHCR), *Listen and Learn: Participatory Assessment with Children and Adolescents*, 2012, available at: **http://www.refworld.org/docid/4fffe4af2.html**

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