NATIONAL STANDARD OPERATING PROCEDURES (SOPs) FOR PREVENTION OF AND RESPONSE TO GENDER-BASED VIOLENCE (GBV) IN SUDAN

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The National Standard Operating Procedures (SOPs) for Prevention and Response to Gender-Based Violence (GBV) in Sudan were developed under the leadership of the Unit for Combating Violence against Women and Children (CVAW). This document is the result of extensive consultations with the government and national and international stakeholders active in Sudan. The SOPs steering committee sincerely thanks all those involved in the production of these procedures.

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ACRONYMS

CMR	Clinical Management of Rape
CP	Child Protection
CSO	Civil Society Organization
CVAW	Unit for Combating Violence Against Women and Children
FCPU	Family and Child Protection Unit
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender-based Violence
GBVIMS	Gender-based Violence Information Management System
GBV-SC	Gender-based Violence Sub-Sector
HCT	Humanitarian country team
HIV	Human immunodeficiency virus
HRP	Humanitarian response plan
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
MHPSS	Mental health and psychosocial support
NFIs	Non-Food Items
NGO	Non-governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PC	Protection Cluster
PCW	Protection of Children and Women
PFA	Psychological first aid
PSEA	Prevention of sexual exploitation and abuse
PSS	Psychosocial Support
PTSD	Post-traumatic stress disorder
RH	Reproductive Health
SCA	Survivor-centred Approach
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-based Violence
SOPs	Standard Operation Procedures
STIs	Sexually transmitted infections
ToR	Terms of Reference
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
VAWG	Violence Against Women and Girls
VAW	Violence Against Women
WFP	World Food Program
WG	Working Group
WHO	World Health Organization

INTRODUCTION

INTRODUCTION

Gender-based violence (GBV) issues represent an essential component of the Sudanese society's realities with interconnected reasons and factors that cut across cultural. Economic and social dimensions, in addition to the conflict that affects family and community stability, and explicitly exacerbating the suffering of women, girls, and children. The space occupied by programs and activities of prevention and response against GBV is of critical importance and urgency, as translated through coordination and cooperation activities between the partners and actors in this field. These Standard Operating Procedures (SOPs) for the prevention of and response to GBV represent an essential development to ensure the delivery of an integrated and high-quality system of services for survivors of GBV. At the same time, they adhere to the international best practice of preventing and responding to GBV to ensure the protection of women, girls, and children and safeguard their rights in cooperation with all partners in roles and responsibilities.

This document coincides with the critical political changes witnessed by Sudan. It is aligned with the state's efforts to review policies related to women and children in general and the strategies related to GBV, in particular

[1]THE PURPOSE AND SCOPE OF THE STANDARD OPERATING PROCEDURES (SOPs)

These SOPs describe guiding principles, procedures, roles, and responsibilities in the prevention of and response to GBV for all actors, including government institutions, UN agencies, national and international organizations. The SOPs provide information on services for a broad group of beneficiaries, including the internally displaced persons (IDPs), refugees, returnees, the host population, and those who remained in their communities during and after conflicts. Building on best national and international practices, these procedures have been developed through a consultation process with service providers in GBV and other key sectors including the medical, psychosocial support, security and justice sectors. *(See signatory page for organizations which endorse the SOPs).*

The SOPs describe the minimum actions to be taken to respect international standards and a survivor-centered approach in caring for GBV survivors in Sudan. They indicate which organizations and/or institutions are responsible for actions in the four main response sectors – health, psychosocial support, law/justice, and security.

The SOPs document is not intended as a stand-alone resource. It should be read in conjunction with other existing resources related to prevention and response to GBV.

RATIONALE OF DEVELOPING THE SOPs

Research indicates an increase in GBV and the need to develop procedures to be applied in the field of prevention and response to GBV. These procedures facilitate the following:

1. Assisting all survivors of GBV through providing confidential, effective and coordinated services;
2. Determining the roles and responsibilities of each sector and/or institution active in the field of prevention and response to GBV.

[1] The GBV SOPs will be reviewed regularly to ensure that they are up-to-date and reflect practices and changes in the context of prevention and response to GBV in Sudan and any changes in international guidelines

INTENDED USERS

The intended users of the SOPs are all actors and service providers that are engaged in GBV response and prevention programming in Sudan.

CHAPTER 1: DEFINITIONS AND TERMS

1.1 DEFINITIONS SPECIFIC TO GBV

Gender: refers to the social differences between men and women that are learned, and though deeply rooted in every culture, are changeable over time and have wide variations both within and between cultures[2].

Gender-based violence (GBV): An umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private[3].

Domestic violence/intimate partner violence: There is no definition for domestic violence in Sudan, and the GBV information management system (GBV IMS) does not define this kind of violence as one of the core types of GBV. It is, however, defined by the relationship between perpetrator and survivor. It is any type of violence that occurs in the household or family, including intimate partner (spouse) violence and violence committed by a family member. Domestic violence may include multiple forms of violence (rape, sexual assault, physical assault, and psychological/emotional abuse).

Female Genital Mutilation/Cutting (FGM/C): Refers to all procedures involving partial or total removal of the external female genitalia or another injury to the female genital organs for non-medical reasons. FGM/C is considered one of the violent acts that affect the genitals and is thus defined as sexual violence. This harmful practice should be classified under sexual assault. In 2016, a proposed amendment to the Criminal Act was adopted by the Council of Minister of Sudan.

The following table provides definitions of terms in the Sudanese framework, drawing on both international and national sources. Service providers in the field of prevention and response to GBV need to be aware of and use these definitions to classify incidents of GBV.

Definitions of GBV Information Management System (GBVIMS)[4]	National Definitions
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.	**Rape:** Article (149) of the **Sudan's Criminal Act of 1991 Amen. 2015** defines rape: In Article 149: (First) Clause (1) and (2) shall be nullified and replaced by the following new clause: There shall be deemed to commit the offence of rape, whoever makes part contact by way of penetrating a sexual organ or any object or part of the body into the victim's vagina or anus by way of using force, intimidation, or coercion by fear of the use of violence,

[2] IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)

[3] IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)

[4] GBV Information Management System (GBVIMS) is an initiative that enables humanitarian actors responding to incidents of GBV to effectively and safely collect, store, analyze and share data reported by GBV survivors. For more information, refer to http://www.gbvims.com

	detention, psychological persecution, temptation or abuse of power against the person or another person, or when the crime is committed against a person incapable of expressing consent because of natural cases or luring-related or related to age. **Penalty:** according to Article (149), whoever commits the offence of rape, shall be punished, with whipping a hundred lashes, and with imprisonment, for a term, not exceeding ten years, unless rape constitutes the offence of adultery, or sodomy, punishable with death. According to Article (45-b) of the Child Act of 2010, the penalty for rape of children is the death penalty or imprisonment for the term not exceeding twenty years and with fine. There is no specific prohibition of marital rape in Sudan and there is no law allowing an alleged rapist to marry the victim to avoid punishment. According to Art. (135) of the Sudan Criminal Act of 1991: (1) There shall be deemed to commit the offence of abortion whoever internationally causes a woman to miscarry a quick unborn child unless the miscarriage occurs in any of the following cases: (a) Where the miscarriage is necessary to save the mother's life; (b) Where the pregnancy, is the result of rape which has occurred before not more than ninety days and the pregnant woman has desired the miscarriage thereof; (c) Where it is proved that the quick unborn child has died in his mother's womb;
Sexual assault: any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape; unwanted kissing; fondling, or touching of genitalia and buttocks. This incident does not include rape, i.e. where penetration has occurred.	**Sexual harassment in the Sudan's Criminal Act of 1991 Amen. 2015, Article (151) on Gross Indecency and Sexual Harassment States:** There shall be deemed to commit the offence of sexual harassment whoever commits an act or speaks or behaves in a way that causes seduction or temptation for another person to engage in illegal sex, or to commit indecent or inappropriate behavior of a sexual nature that psychologically harms the victim or makes the victim feel unsafe, shall be punished with

	imprisonment, for a term not exceeding three years and whipping. According to court precedent (ma/tg/2013), sexual harassment includes sexual phrases or gestures and touching private parts of the victim. In Sudan there is no explanatory note to explain the concept of sexual harassment.
Physical assault: An act of physical violence that is not sexual in nature. Example include: beating, slapping, strangling, cutting, pushing or burning in all its forms, including using acids, shooting or use of any weapons, or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.	**Physical assault:** The Sudan's Criminal Act of 1991 considers physical assault a crime called "causing intentional wounds": 1. Whoever commits the offense of causing intentional wounds, shall be punished, with retribution *"Qisas"*, where its conditions are satisfied, and where the conditions are not satisfied, or retribution *"Qisas"* is remitted, he shall be punished, with imprisonment, for a term, not exceeding five years, or with fine, or with both, without prejudice to right to "*Diya*". 2. Whoever commits the offence of causing intentional wounds in the Southern States shall be punished, with imprisonment, for a term, not exceeding five years, or with fine, or with both, without prejudice to right to "*Diya*". Article (142) is on the offence of "hurt": 1. There shall be deemed to commit the offence of hurt whoever causes any pain, or disease to another person, and shall be punished, with imprisonment, for a term, not exceeding six months, or with fine, or with both. 2. Where hurt has occurred by dangerous means, such as poison, or intoxicating drugs, or where hurt is caused with the intention of drawing a confession from another, or compelling that other to do an act contrary to the law, the offender shall be punished, with imprisonment, for a term, not exceeding two years, and may also be punished with fine.
Forced marriage: The marriage of an individual against his/her will. This also includes child marriage which is any marriage under the age of 18.	**Forced marriage:** There is no legislation in Sudan to prohibit child marriage. The 2010 Child Act does not mention marriage in this context.

	Article (40-3) in the Sudan's Personal Status Law of 1991 cites that once a party is 10 years old they may be married with the consent of their parent or guardian. "The guardian of a minor girl cannot conclude her marriage contract unless there is permission from the judge. The guardian has to prove that the marriage will benefit the minor girl, that the husband is suitable and the husband pays the dowry usually paid to women of her status." Sudan ratified the Convention on the Rights of the Child in 1990, which sets a minimum age of marriage of 18.
Denial of resources, opportunities, or services (economic violence): Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a woman prevented from receiving an inheritance, earnings forcibly taken by an intimate partner/spouse or family member, denying girls educational opportunities, a woman prevented from using contraceptives, a girls prevented from attending school, etc. Reports of general poverty should not be recorded.	
Psychological/emotional abuse: Infliction of mental or emotional pain or injury. Examples include: threats of use of physical or sexual violence, intimidation, humiliation, forced isolation, chasing, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.	**Psychological/emotional abuse:** Violating this right can be prosecuted under Article (143) of the Criminal Act of 1991, use of Criminal Force: "There shall be deemed to commit the offence of the use of criminal force, whoever uses force upon another person, without that person's consent, intending to commit any offence, or to cause harm, or fear, or annoyance to such person, and shall be punished, with imprisonment, for a term, not exceeding one year, or with fine, or with both. **And Article (144), Intimidation:** 1. There shall be deemed to commit the offence of intimidation whoever: (a) Threaten to harm another, or any person in whom that other is interested, intending thereby to threaten, or compel him to do what he is legally not bound to do, or forbear from doing what he is legally bound to; (b) Makes any gesture, or preparation intending thereby to use criminal force,

or knowing that such gesture, or preparation is likely to make any person present to apprehend that he is about to use criminal force, against him.

2. Whoever commits the offence of intimidation shall be punished, with, imprisonment, for a term, not exceeding six months, or with fine, or with both.

And Article (156), Seduction:

"Whoever seduces any person by inducing, taking or assisting in taking or abduction of such person, or hiring him to commit the offence of adultery, or sodomy, or obscene practicing prostitution, or gross indecency, or obscene acts or acts contrary to public morality, shall be punished with whipping not exceeding a hundred lashes or with imprisonment for a term not exceeding five years and if the person so seduced is a minor, or a person of unsound mind, or if the exercise of any of such acts is intended to be committed outside of Sudan, he shall be punished with whipping not exceeding a hundred lashes and with imprisonment for a term not exceeding 7 years.

And Article (157), False accusation of unchastity:

1. There shall be deemed to commit the offence of false accusation of unchastity *"Qazf"* whoever falsely whether expressly or by implication or in writing or clear signal imputes adultery or Sodomy or negation of lineage to chaste person even if such person is dead.
2. A person is deemed to be chaste when he has not been convicted of adultery or sodomy or rape or incest or practicing prostitution.
3. Whoever commits false accusation of chastity *"Qazf"* shall be punished, with whipping eighty lashes.

And Article (159), Defamation:

1. There shall be deemed to commit the offence of defamation whoever punishes or narrates or otherwise communicates to another by any means facts imputed to a specific person or evaluation of his

	conduct intending thereby to injure his reputation. 2. A person shall not be deemed to intend to injure the reputation of another in any of the following cases: (a) Where he made it in the course of judicial proceedings to the extent required by the same or a publication of such proceedings; (b) Where he or another person has a lawful complaint or interest to be expressed or protected respectively which cannot be achieved without the imputation of such factors or evaluation of the particular conduct; (c) Where it is made about a person elected for a public office or assumes the same with intent to evaluate his capacity, or his performance to the extent that such evaluation is necessary; (d) Where it is made about a person in the course of an advice for the interest of another person intending to deal with, him or for the public interest; (e) Where the facts are imputed in good-faith to a person, who is reputed of and in the habit of doing them or who publicly does what is imputed to him; (f) Where it is made in the course of evaluation of a person who has placed himself or his work for judgement by the public opinion and such evaluation is to the extent necessary for such judgement. 3. Whoever commits the offence of defamation shall be punished with imprisonment for a term not exceeding six months or a fine or with both. **And Article (160) Insult and Abuse:** Whoever directs insults or abuse not amounting to false accusation *"Qazf"* or defamation to any person intending thereby to humiliate him shall be punished with imprisonment for a term not exceeding one month or with whipping not exceeding twenty-five lashes or with fine.

Note: All of the above definitions apply to both children and adults.

1.2 DEFINITIONS RELATED TO CHILD PROTECTION

- **The best interest of the child**: broadly describes the wellbeing of a child. Wellbeing is determined by a variety of individual circumstances, such as the age, the level of maturity of the child, the presence or absence of parents/caregivers, the child's environment and experiences[5]. For ways to determine the best interest of the child, see the UNHCR Guidelines on Determining the Best Interests of the Child, 2008.
- **Child/minor:** any person under the age of 18[6].
- **Child Abuse**: child abuse is a deliberate act of ill-treatment or omission that can harm or is likely to cause harm to a child's safety, wellbeing, dignity, and development. Abuse includes all forms of physical, sexual, psychological, or emotional ill-treatment and results in harm. Harm can take many forms, including impacts on children's physical, emotional, and behavioral development, their general health, family and social relationships, self-esteem, educational attainment, and aspirations for the future[7].
- **Child survivor:** a person under the age of 18 who has experienced any form of violence, especially GBV[8]. According to the regulation on dealing with children survivors of 2012, these are children under 18 victims of crime or witnesses notwithstanding their alleged offense.
- **Child protection:** the prevention of and response to abuse, neglect, exploitation of and violence against children in emergencies[9].
- **Child marriage**: a formal marriage or informal union before age 18, and it applies both to boys and girls, even though the girls suffer inordinately. Even though some countries permit marriage before age 18, international human rights standards classify these as child marriages, reasoning that those under age 18 are unable to give informed consent[10]. Therefore, early marriage is also a form of forced marriage as children are not legally competent to agree to such unions. Article 15 of the Transitional Constitution protects children against early marriage in the Sudan while the Personal Affairs Act is not clear on the legal marriage age. Article (40-3) in the Sudan's Personal Status Law of 1991 cites that once a party is 10 years old they may be married with the consent of their parent or guardian. "The guardian of a minor girl cannot conclude her marriage contract unless there is permission from the judge. The guardian has to prove that the marriage will benefit the minor girl, that the husband is suitable and the husband pays the dowry usually paid to women of her status."
- **Child sexual abuse:** refers to any sexual activity between a child and a closely related family member (incest) or between a child and an adult or older child from outside the family. It involves either explicit force or coercion or, in cases where the victim cannot give consent because of his or her young age, implied force[11].
- **Children exposed to delinquency:** refers to the child who attained seven but under twelve years of age, who is found in an environment that exposes his moral, psychological, physical, or educational safety to danger[12].

[5] Convention on the Rights of the Child, (1989)
[6] Convention on the Rights of the Child, (1989) and Sudan Child Act of 2010
[7] IRC and UNICEF, Care for Children Survivors of Sexual Abuse: Guiding Principles for Health, Psychological and Social Services in Humanitarian Emergencies, (2012)
[8] Convention on the Rights of the Child, (1989)
[9] Global Child Protection Working Group definition: www.cpwg.net
[10] UNICEF. Child Protection from Violence, Exploitation and Abuse. Thematic report, (2011)
[11] Convention on the Rights of the Child, (1989)
[12] Sudan Child Act 0f 2010

- **Children without parent/caregiver care:** All children abandoned by parents because of stigma or poverty or for any other reasons, and no other relative provided care for him/her[13].
- **Children in conflict with the law:** Any child who is 12 years and above and below 18 when he commits an unlawful act[14]. Children who come into conflict with the justice system as a result of being suspected, accused, or convicted of an offense.
- **Children associated with armed forces or armed groups**: Refers to any person below 18 years of age who is or who has been recruited or used by an armed force (government military or other security forces) or armed (opposition) groups in any capacity, including but not limited to children (boys and girls) used as fighters, cooks, porters, messengers, spies or for sexual purposes. This includes children who provide information to armed groups or forces, who distribute pamphlets on behalf of these groups/forces, or who transport material or work as mechanics. It does not include children who show support for either the opposition or government forces without any instruction from or agreement from members of armed groups (e.g., through participation in demonstrations, throwing stones, or writing slogans on walls)[15].
- **Emotional or psychological abuse:** is the persistent emotional maltreatment of a child, such as to cause severe and persistent adverse effects on the child's emotional development and psychological wellbeing. It includes humiliating and degrading treatment (e.g., name-calling, constant criticism, belittling, persistent shaming, confinement, and limiting social interaction).
- **Neglec**t: persistently failing to provide for or secure for a child, their basic physical, developmental, or psychological needs, whether deliberately or through carelessness or negligence. Neglect is sometimes called the "passive" form of abuse, as it relates to the failure to carry out some key aspects of care and protection, resulting in the impairment of the child's health or development. It may include unresponsiveness to meet the child's most basic emotional needs. Neglect does not include situations of poverty, where a parent/caregiver cannot afford to provide for their child but is trying to do so[16].
- **Physical abuse:** An act of physical violence that is not sexual and causes actual or likely physical injury or suffering (for example, hitting, shaking, burning, torture, stoning etc.). Physical abuse can take place in the home, the community, and schools.
- **Separated child:** A child separated from both parents/caregivers or his/her previous legal or primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.
- **Unaccompanied child:** A child who has been separated from both parents/caregivers and other relatives and who is not being cared for by an adult, who by law or custom, is responsible for doing so. This means that a child may be completely without adult care or maybe cared for by someone not related or known to the child, or not their usual caregiver, e.g., a neighbor, another child under-18, or a stranger.
- **Violence against children:** the intentional use of physical force or power, threatened or actual, against a child, by an individual or a group, which either results in or has a high likelihood of resulting in actual or potential harm to the child's health, survival, development or dignity. This can also include self-inflicted violence, such as self-harm or suicide.

[13] Sudan Child Act of 2010
[14] Sudan Child Act of 2010

[16] Convention on the Rights of the Child, (1989)

- **The worst form of child labour:** these include slavery, prostitution and pornography, illicit activities, and work likely to harm children's health, safety, or morals as defined in the ILO Convention No. 182[17].

1.3 OTHER RELATED DEFINITIONS AND TERMINOLOGY

- **Actors/service providers:** refers to individuals, groups, organizations and institutions involved in preventing and responding to GBV. Actors may be refugees/internally displaced persons, local populations, employees or volunteers of UN agencies, NGOs, host government institutions, donors, and other members of the international community[18].
- **Affected community:** the term refers to populations affected by an emergency including refugees, internally displaced persons, and host populations.
- **At-risk group(s)**: Group(s) of individuals more vulnerable to harm from other members of the population because they hold less power, are more dependent on others for survival, or less visible to relief workers, or are otherwise marginalized.
- **Case management:** is a structured method for providing help to a survivor. It involves one organization, usually a psychosocial support social services actor, taking responsibility for making sure survivors are informed of all the options available to them; that issues and problems facing a survivor and their family are identified and followed up in a coordinated way, as well as providing the survivor with emotional support throughout the process[19].
- **Case manager: A** person who is entrusted with the responsibility of providing services to survivors[20].
- **Conflict-related sexual violence:** Incidents or patterns of sexual violence that take place in conflict or post-conflict situations or other situations of concern such as political strife that may have a direct or indirect relationship with the conflict or political conflict. It includes rape, sexual slavery, forced prostitution, forced pregnancy, forced abortion, enforced sterilization, forced marriage and any other form of sexual violence of comparable gravity perpetrated against women, men, girls or boys, which are directly or indirectly linked to a conflict. The term also encompasses trafficking in persons for sexual violence or exploitation, when committed in situations of conflict[21].
- **Confidentiality:** An ethical principle associated with medical and social service professions. Maintaining confidentiality requires service providers to protect information gathered about clients and agree only to share information about a client's case with their explicit permission. Maintaining confidentiality about abuse means service providers never discuss case details with family or friends or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children or clients who express intent to harm themselves or someone else[22].

[17] ILO Convention No. 182
[18] IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)
[19] UNICEF. Community Protection program: Changing People's lives and Preventing Violence, (2014)
[20] IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)
[21] Secretary General's report on GBV in Conflicts, (2017)
[22] IRC and UNICEF, Care for Children Survivors of Sexual Abuse: Guiding Principles for Health, Psychological and Social Services in Humanitarian Emergencies, (2012)

- **Coordinating agencies**: The organizations that take the lead in chairing the GBV sub-sector and/or working groups ensuring that the minimum prevention and response interventions to GBV are established.
- **Disability:** Is an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others[23]. The Sudan Child Act of 2010 defines the term as any child, who by reason of physical, a mental or visual disability that affects him/her partially or totally.
- **Harmful traditional and cultural practices:** Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members. In contrast, others are harmful to a particular group, such as women. These harmful traditional practices include FGM/C; forced feeding of women; child marriage; the various taboos or practices that prevent women from controlling their fertility; nutritional taboos and traditional birth practices; son preference and its implications for the status of the girl child; female infanticide; early pregnancy; and dowry price. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called honor crimes and dowry-related violence, exorcism or "witchcraft"[24].
- **Incident:** refers to the specific act of gender-based violence or rights violation.
- **Informed consent:** The voluntary agreement of an individual who can give consent for general services. The individual must have the capacity and maturity to know about and understand the services being offered and be capable of giving their consent. Parents, caregivers, or other legal guardians are typically responsible for providing consent for their child to receive services until the child reaches 18 years of age[25].
- **Internally displaced persons (IDPs):** Persons who seek protection in other parts inside their country of origin or the place of their residence and did not cross any internationally recognized after being forced to flee to escape the effects of armed conflict or systematic violations of human rights or natural or human-made disasters.
- **Mandatory reporting:** Laws and policies that mandate certain agencies and/or persons active in assistance professions (such as teachers, social workers, health staff, and others) to report actual or suspected abuse (such as physical abuse, emotional/psychological abuse, sexual assault or neglect)[26]. The Sudan Child Act of 2010 discussed in the definition of reporting the loss of the right to care in Article 84, as any person who has reasonable reason to believe that there is a violation of the rights of any child, or that anyone of the child parents, his guardian, or whoever may be entrusted with his care refuses or neglects supplying the child with sufficient food, clothes, healthcare or education while capable of doing that, shall inform that to the nearest official authority.
- **Monitoring and Reporting Mechanism (MRM) on Grave Violations of Children's Rights in Situations of Armed Conflicts:** A mechanism mandated by the UN Security Council to provide

[23] Preamble of the UN Convention on Rights of t Persons with Disability, (2006)
[24] IASC, Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)
[25] IASC, Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)
[26] IRC and UNICEF, Care for Children Survivors of Sexual Abuse: Guiding Principles for Health, Psychological and Social Services in Humanitarian Emergencies, (2012)

timely and reliable information on six grave children's rights violations to be included in the Secretary General's report on Children and Armed Conflicts. The MRM aims at ending and preventing violations committed against children in the context of armed conflicts and holding parties in the conflict accountable for these violations and provide appropriate responses on behalf of the affected children.

- **Monitoring and analysis and reporting sexual violence related to conflict (MARA):** A mechanism to ensure the systematic collection of timely, accurate, reliable, and objective information on conflict-related sexual violence against women, men, and children. Information from MARA is used to promote appropriate and timely action to prevent and respond to conflict-related sexual violence and inform strategic advocacy with the Security Council and other political and policy-making bodies, as well as with Governments, donors, and international media.
- **Perpetrator:** A person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against their will.
- **Post-traumatic Stress Disorder (PTSD):** A disorder that occurs and develops in some persons due to a shock or tremendous psychological pressure.
- **Psychosocial support:** Support that aims to protect or promote the psychosocial wellbeing and/or prevents or treat mental disorders[27]. Psychosocial support helps in rebuilding social structures after emergencies and crises and could help change persons from negative victims to positive survivors.
- **Psychological first aid (PFA):** Humane, supportive and practical assistance to survivors of GBV. This includes listening but not pressuring people to talk, providing information on available support services, and helping to access basic needs such as food and water.
- **Referral pathway:** A flexible mechanism that safely links survivors to supportive and competent services, such as medical care, mental health, psychosocial support, police assistance, and legal/justice support.
- **Refugee:** Any person, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country[28].
- **Survivor:** A person who has experienced GBV. The terms "victim" and "survivor" are often used interchangeably. Victim is a term more used in the legal and medical sectors. Survivor is the term generally preferred in the psychological and social support sectors as it implies resiliency. The term "survivor" will be used in these SOPs[29].
- **Survivor-centered approach (SCA):** The survivor-centered approach can guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. It aims to create a supportive environment in which a GBV survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect. The approach helps to promote a

[27] IASC, Guidelines on Mental Health and Psychosocial Support in Emergency Settings, (2007)
[28]UN Convention Relating to the Status of Refugees, Article 1, 1951
[29]IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)

survivor's recovery and strengthen her or his ability to identify and express needs and wishes; it also reinforces the person's capacity to make decisions about possible interventions[30].

- **Trafficking**: The recruitment, transportation, transfer, harboring or receipt of persons by means of the threat of use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a p[position of vulnerability or of giving or receiving of payment or promise of benefits to secure the consent of a person in control of the victim for the purposes of exploitation including exploiting the prostitution of others, forced labour, slavery or similar practices and the removal of organs[31].
- **Women and girls' friendly spaces:** A formal or non-formal place where woman and girl feel physically and emotionally safe. The term" safe" refers to the absence of trauma, excessive stress, violence (or fear of violence), or abuse. It is a space where women and girls, being the intended beneficiaries, feel comfortable and enjoy the freedom to express themselves without the fear of judgment or harm[32]. These spaces may take different names such as women centers, women community centers, or listening and counseling centers, to name a few. Women safe spaces are not the same as shelters or safe spaces at reception centers or one-stop centers.

[30] IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)
[31] UN. Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, (2000)
[32]UNFPA. Women and Girls- friendly Spaces, Guidance Note based on Lessons Learnt for the Syrian crisis

CHAPTER 2: GUIDING PRINCIPLES

All actors in these SOPs agree to extend the fullest cooperation and assistance to each other in preventing and responding to GBV and agree to adhere to and promote the following set of guiding principles:

2.1 GBV GUIDING PRINCIPLES FOR ALL ACTIONS

All actors in these SOPs commit to the set of guiding principles aimed at ensuring that the staff and volunteers integrate GBV into their work and that interventions and programs are gender-sensitive, cooperative, and participatory. **These are:**

- Understand and adhere to the ethical and safety recommendations in the WHO Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies (WHO 2007)[33]. *(Refer to Annex 2: WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies).*
- Extend the fullest cooperation and assistance between organizations and institutions in preventing and responding to GBV. This includes sharing situation analysis, assessment information, identifying needs, and analyzing GBV trends in Sudan to avoid duplication, maximize a shared understanding of the situation and ensure the best utilization of available resources.
- Design and implement joint multi-sectoral and inter-organizational interventions for GBV prevention and response.
- Engage the community fully in understanding and promoting gender equality and power relations that protect and respect the rights of women and girls.
- Ensure equal and active participation by women and men, girls and boys in assessing, planning, implementing, monitoring, and evaluating programs through the systematic use of participatory approaches.
- Integrate and mainstream GBV interventions into all programs and all sectors;
- Ensure accountability at all levels; to local communities and among all actors working in any sector;
- Ensure all staff and volunteers involved in prevention and response to GBV understand and sign a code of conduct or similar document setting out the same standards of conduct. *(Refer to Annex 3: Sample Sexual Exploitation and Abuse Code of Conduct).*
- Avoid exposing survivors to further harm as a result of your actions. Before introducing new interventions, find out how issues to be addressed were handled previously by survivors, families, the communities and the authorities;
- Gain a full understanding of the expected behaviors and social norms for women, men, boys, and girls and take these into account when planning interventions.

2.2 GUIDING PRINCIPLES FOR WORKING WITH SURVIVORS OF GBV

All actors involved in these SOPs agree to adhere to a set of guiding principles aimed at minimizing the harm to the GBV survivor and maximizing the efficiency of GBV prevention and response interventions.

The four principles to care for GBV survivors and the related skills are considered essential for a survivor-centered GBV intervention. Service delivery informed by these principles of safety,

[33] WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies, (2007)

confidentiality, dignity, and non-discrimination fosters empowerment and control for survivors and promotes a survivor's safety, wellbeing, and recovery.

Organizations should ensure all staff members and volunteers receive training so they can apply the relevant skills to uphold these four principles.

2.2.1 Right to safety:

The safety and security of the survivor and others, such as their children, their families, and people who have assisted them, must be the priority for all actors. Persons who disclose an incident of GBV or a history of abuse are often at high risk of more violence from the perpetrator(s) or others around them. **Therefore:**

- Conduct conversations, assessments, and interviews in a quiet and private place.
- Assess the safety of the survivor and promote security measures the survivor believes should be taken.
- Only take action with the informed consent of the survivor.

2.2.2 Right to confidentiality:

Confidentiality reflects the belief that people have the right to choose to whom they will or will not tell their story. It also means not disclosing any information at any time to any party without the informed consent of the concerned survivor. Confidentiality bolsters safety, trust, and empowerment**. Therefore:**

- Respect the confidentiality of survivors and their families at all times.
- If the survivor gives his/her informed consent, share only relevant information with other professionals (i.e., for referrals).
- Do not discuss any information with the survivor, related to the incident, perpetrator or legal response in the presence of other beneficiaries or the survivor's children;
- Keep records and all written information about the survivors in a secure location at all times. A number or code should identify files, and electronic files must be protected by passwords (in case of digital saving of records).

2.2.3 Right to dignity and self-determination:

The survivor is the primary actor. The role of helpers is to facilitate recovery and provide resources for problem-solving. All actions taken should be guided by respect for the choices, wishes, rights, and dignity of the survivor.

- Respect the strength and capacities of the survivor to cope with what has happened to them.
- Show that you believe the survivor, that you don't question or blame the survivor, and that you respect their privacy.
- Be patient and do not press for more information if the survivor is not ready to speak about his/her experience.
- Ask only relevant questions and do not push the survivor to reveal details of the incident if they are not necessary for the provision of services (such as medical care).
- Avoid requiring the survivor to repeat the story in multiple interviews.
- Be respectful and maintain a non-judgmental manner. Do not laugh or show any disrespect for the individual, or his/her culture, family, or situation.
- Provide emotional support to the survivor. Show empathy, understanding, and willingness to listen.
- Use easily understood language with the survivor. Provide the survivor with information about available services and the quality of these services.

- Consult the survivor on where he/she wishes to seek help and respect his/her wishes. Do not push, suggest, or otherwise guide his/her in any specific direction.
- Be clear about your role and the type of support and assistance you can provide. Never make promises that you cannot fulfill.
- Make sure you are well informed about the options for referral (e.g., medical, psychosocial, economic, judicial), including what services are available, the quality of these services, and the safety for survivors when accessing these services.
- Ensure attention to survivors' various needs, including medical and psychosocial needs, material needs, and the need for safety and security.
- Conduct interviews and examinations with staff and translators of the same-sex of survivors or as preferred by the survivor. In the case of young children, female interviewers are the best option.
- Consider the possibility of accompanying the survivor throughout the process, if necessary.

2.2.4 Right to non-discrimination:

Survivors of GBV must receive equal and fair treatment regardless of age, gender, race, ethnicity, nationality, or any other characteristic**, therefore:**

- Ensure the provision of services in a dignified and equal manner.
- Do not make assumptions about the history or background of a survivor.
- Be aware of your prejudices and opinions about GBV, and do not let these influence the way you treat a survivor.
- Ensure you have been trained on human rights and humanitarian principles, and relevant agency non-discrimination policies.

2.3 GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS OF GBV

All actors in these SOPs and GBV intervention should apply the above principles to children, including their right to participate in decisions that will affect them. Service providers caring for child survivors of GBV should adhere to a set of additional principles to guide decision-making and overall quality of care. They must ensure children and families receive the best care possible.

2.3.1 Work according to the best interests of the child:

This vital principle should be applied both to decisions relating to individual children and to broader policy matters and decisions relating to groups of children. In every decision affecting children, the various possible solutions must be considered, and due weight must be given to the child's best interests. The decision about how to establish a child's best interests can often be difficult, and no single answer may be obviously and indisputably correct. There are several factors to be considered, including age, gender, cultural background, the general environment, and past experiences of the child. Therefore, any interpretation of this principle must give due regard to expert advice from both legal and child development perspectives.

2.3.2 Ensure the safety of the child and their right to life, survival, and development:

- Ensure the physical and emotional safety of children during care and treatment.
- All case actions taken on behalf of a child must safeguard a child's physical and emotional wellbeing in the short term and the long term.

2.3.3 Comfort and support the child:

Children who disclose sexual or other types of abuse require comfort, respect, and support from all service providers. **Therefore:**

- Believe children who disclose abuse and never blame them in any way for the harm they have experienced.
- Make children feel safe and cared for as they receive service.
- Ensure that appropriate support is provided to the children to recover from the physical, psychological, and social effects of the violation.
- Provide counseling to children survivors of violence.

2.3.4 Ensure appropriate confidentiality:

Information about a child's experience of abuse should be collected, used, shared, and stored confidentially. **This means ensuring:**

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

Under the Sudan Child Act of 2010, service providers are required to report child abuse to the local authorities. Ensure that the child and their guardians/caregivers are informed of the mandatory reporting procedures at the beginning of service delivery. In situations where a child's health or safety is at risk, limits to confidentiality exist to protect the child.

2.3.5 Involve the child in decision making:

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

- Listening to the child's ideas and opinions should not interfere with caregivers' rights and responsibilities to express their views on matters affecting their children;
- While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always respect, empower and support the children, and deal with their concerns in a transparent manner.
- In cases where a child's wishes cannot be prioritized, the reasons should be explained to the child.

2.3.6 Non-discrimination:

All children, at all times, in all circumstances, should be offered the same high-quality care, services, and treatment regardless of race, religion, gender, family situation, or the status of their caregivers, cultural background, financial situation, or unique abilities or disabilities. No child should be mistreated for any reason. This ensures all children are given opportunities to reach their maximum potential.

2.3.7 Strengthen children's resilience:

Each child has unique capacities, strengths, and possesses the ability to heal. Service providers can assist child survivors in recovering by:

- Treat children with dignity and encourage others to do the same;
- Assist them to participate fully in family and community life; and
- Help the child build and maintain healthy relationships.

2.4 GUIDING PRINCIPLES FOR WORKING WITH PERSONS WITH DISABILITY SURVIVORS OF GBV

SPHERE standards identify the rights of all persons to receive humanitarian assistance as a necessary element of the right to life with dignity. This encompasses the right to an adequate standard of living, including adequate food, water, clothing, shelter, and the requirements for good health, which are expressly guaranteed in international law[34]. Any assistance must be provided according to the principles of impartiality and nondiscrimination: noting that no one should be discriminated against on any grounds of status, including disability.

All actors involved in these SOPs agree to adhere to the following principles when working with persons with disability:

2.4.1 Right to participation and integration[35]:

- Strengthen their full inclusion in the community.
- Ensure accessibility to services.
- Ensure equal opportunities, non-discrimination, and respect differences.
- Ensure equality between men and women and between boys and girls.
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

2.4.2 Focus on the individual, not on disability:

- Work with persons with disabilities through a cooperative, participatory process;
- Respect their dignity and independence.
- Ensure consulting them on the best options and explore their interests, priorities, and goals.
- Ensure provision of opportunities to them as to other survivors of GBV.

2.4.3 Don't promote negative power dynamics:

- Do not make decisions on behalf of the survivors. Support their feeling of autonomy and the ability to make their own decisions.

2.4.4 Dealing with caregivers and families:

Disability can affect family members, particularly women and girls, who could assume the role of care providers. Understand the concerns, priorities, and goals of care providers and promote healthy relationships and balanced power dynamics between the care providers, persons with disabilities, and their families.

[34] Sphere - The Humanitarian Charter and Minimum Standards in Humanitarian Response.
[35] UN Convention on the Rights of Persons with Disability – General Principles, (2006)

CHAPTER 3: REPORTING, REFERRAL AND CASE MANAGEMENT

1.3 GBV DISCLOSURE

This chapter guides all actors on how to respond when a survivor discloses a GBV incident.

A survivor has the freedom and the right to disclose an incident of GBV to anyone. They may reveal their experience to a trusted family member or friend or may seek help from an individual or organization in the community. The survivor has the right to disclose as little or as much of what happened to them and choose when to disclose information.

General service providers should:

- Provide support and assistance to GBV survivors who disclose an experience of GBV. When a survivor contacts a service provider, they have a responsibility to give honest and accurate information about services available; to provide a reasonable time within which services can be expected; to explain the consequences (pros and cons) of accessing any service; to provide details on how to access these services, and provide the appropriate support to the survivor to access such services.
- All organizations should be prepared to receive disclosures of GBV, including organizations that do not provide GBV specialized services, **should at a minimum:**
  - ✓ Train all staff on GBV guiding principles and standard operating procedures relevant to their specialization.
  - ✓ Ensure all staff know the available specialized GBV service in their area.
- Create a safe, supportive, confidential environment that allows survivors, children and/or their caregivers to disclose violence should they choose to do so.
- General services providers or community volunteers should not attempt to actively identify survivors of GBV or child protection issues as this can lead to stigma and put survivors/children and staff/volunteers at risk.
- When dealing with disclosure of GBV incidents, it is essential to respect the dignity of the survivor regardless of personal convictions. All staff in specialized and non-specialized GBV organizations should be aware of the survivor-centered approach. Initial information received by the survivor could indicate whether they are going to get any additional care.
- Non-specialized actors should not interview survivors or respond directly. The interviews should be done by specialized GBV actors who could provide immediate emotional and/or medical support.
- The wishes of the survivor must always be respected as to where or with whom to seek help. They should not be urged into a particular course of action.
- Non-specialized actors should ask the survivor's consent to contact a primary focal point on the GBV referral pathway and facilitate the contact between the service provider and survivor. If a survivor consents to share their information, the referral should be made accompanying the survivor or phone. All actors should be familiar with the referral pathways, the available services, the policy of mandatory reporting (if that exists), and the informed consent before the survivor could be referred safely, timely and appropriately. Referrals done without the consent of survivors may cause more harm and stigma. In cases of danger/threat to life, and in cases of children, contact the specialized case management institutions in the area immediately.
- All information should be kept confidential, even if family or community members request feedback on the support given.
- In some cases, women groups could play an essential role in referral as they can represent an entry point for assistance in the community. Members of such women groups must be trained on how to deal with disclosures of GBV incidents and must know

of all available services and when and how they can be accessed to ensure safe and appropriate referrals.

Steps for GBV specialized and non-specialized actors[36]:

1. **Prepare:**
   - Be aware of how to communicate with survivors in a survivor-centered manner.
   - Be aware of available services.
   - Increase your knowledge and skills as a non-GBV practitioner.
2. **Welcome:**
   - Find a safe and quiet space to talk.
   - Ensure the survivors are not left alone.
   - Ask the survivor about what their immediate concerns are.
   - Assess the security and safety of the survivor – evaluating together.
   - If the survivor is distressed, help them to calm down.
   - Ask if you can provide help.
3. **Listen:**
   - Act respectfully to build trust with the survivor and listen to them.
   - Allow the survivor to disclose their distress and seek help.
   - Do not pressure the survivor to talk and do not expect them to display particular emotional reactions.
   - Listen, if they want to talk about what happened.
   - Listen actively, give full attention, gently nod your head, make eye contact, use appropriate body language.
   - Assure the survivor it is not their fault.
4. **Provide information:**
   - Inform the survivor they are entitled to protection from violence, abuse, and to receive care and support.
   - Inform them of the services available, and the benefits and consequences of the available options.
   - If you do not have the information, contact the service provider or the coordinator of the GBV sub-sector.
   - Use language they will understand.
   - Inform the survivor of a realistic timeframe within which services can be expected.
   - For sexual violence survivors, provide information on healthcare services and explain the importance of seeking health care within 72 hours to reduce risks of sexually transmitted diseases (including HIV/AIDS) and unwanted pregnancies.
   - Give the survivor time to take breaks and ask for clarifications.
   - Respect the survivor's right to decide what support they need.
   - Do not give advice or your opinion on what the survivor should do.
5. **Referral:**
   - Refer the survivor to the services they agreed to.
6. **Close:**
   - Positively finish the disclosure.
   - Reaffirm, they are entitled to protection from violence, abuse, and exploitation, and to receive care and support.

[36]IASC. Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, (2015)

- Reaffirm it is not their fault.
- Reaffirm, it is common to feel strong negative emotions in such situations.
- Reaffirm, they have the right to live free from violence and risk of violence.

Relevant rules and policies of mandatory reporting in Sudan

There are no laws stipulating mandatory reporting by any institution regarding GBV cases related to adults in Sudan. On the other hand, reporting GBV incidents against children is mandatory as they are considered a public right. The Child Act of 2010 defines discussed reporting information of violation of the rights of care under Article 84: 1) any person who has reasonable cause to believe that there is violation of the rights of any Child, or that any one of the Child parents, his guardian, or whoever may be entrusted with his care, refuses, or neglects supplying the Child with adequate food, clothing, medical care or education, while he is able to provide the same , shall inform that to the nearest official authority, 2) The competent authority, which has been informed of the matter, under the provisions of sub-section (1), may summon the person, against whom the information is made, and verify the matter therewith; and the competent body may order such , as it may deem achieving the Child interest, 3) Where the person, to whom any order has been issued , under the provisions of sub-section (2), refuses executing such order, the competent body may submit the matter to the nearest Family and Child Protection Unit, together with such recommendations, as it may deem fit, to treat the situation, and the body, to which the matter has been submitted may: a) issue any order, as it may issue under the provisions of this Act, or any other law; b) where the person, to whom the order has been issued, is one of the Child parents, in addition to the order it has issued under the provisions of paragraph (a), require such parent to sign an undertaking to provide the needs of the Child, according to his need therefore .

Article (85) of the same Act discussed means of reporting violations: 1) There shall be established a hot telephone line, or any other means of communication, to receive information, suits and complaints of any violation to any of the Child rights, set out in this Act, provided that the official authorities which receive the information shall be certain of the informant and his address. (2) The police shall establish a center of receiving information, and coordinate with the competent bodies, to intervene. (3) If it appears that there is a false information, the informant shall be tried under the criminal law.

Informed consent and information sharing:

- Informed consent refers to the voluntary agreement of an individual to participate in an event or act after careful consideration and after receiving all the relevant information and facts at the time of giving the consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be capable of giving their consent. Requesting the informed consent of the survivor means asking permission to take any action such as referral or medical examination and sharing information about their experience with other service providers.
- Informed consent is a crucial step in providing quality care and response to a GBV survivor. It should be voluntary and given freely by the survivor based upon their clear appreciation and understanding of the facts, implications, and future consequences of any action that will be undertaken.
- Actors must explain to the survivor any steps involved in the offered service, and inform them about additional available services according to their needs. This must include explaining in detail any potential negative aspects (e.g., cost, distance, lack of female staff) or consequences, in addition to potential benefits related to accessing the services.

- Under no circumstances should the survivor be pressured to consent to any examination, conversation, assessment, interview, or other intervention which they do not feel comfortable doing. A survivor can also at any time decide to stop and intervention (e.g., during a medical examination).
- After disclosing information, the GBV survivor has the right to control how information about their case is shared with other actors or individuals. If the survivor does not consent to share their data (any data), it cannot be shared with any third party.
- Even if a survivor does not provide their consent to share information with other organizations, they are still entitled to receive appropriate and timely care.
- If a survivor comes to you in need of immediate lifesaving help- for example, because they are in imminent danger (the perpetrator or someone else potentially dangerous has followed them) or requires urgent medical attention – you will likely not be able to go through the entire informed consent process. In such cases, if you are going to take action involving others, try to get the survivor's verbal consent before acting.
- If informed consent forms are not available for a survivor to sign, verbal informed consent must be obtained.

Steps of ensuring informed consent:

1. **Provide all information**: To ensure consent is truly informed consent, provide all possible data and options available to the survivor. They must know what is going to happen after the referral. Actors must also explain to the survivor that they have the right to decline or refuse any part of any services.
2. **Ensure the survivor understands the implications of any referral**: Explain the benefits and risks of the service to the survivor. Explain that the survivor has the right to control how the information about their case is shared with other agencies or individuals. The survivor should understand the implications for sharing information so that they can make decisions based on full knowledge before the information is shared.
   Make the survivor aware that their information may need to be shared with others who can provide additional services.
3. **Explain the limitations to confidentiality:** Make the survivor aware that their information may need to be shared with others who can provide additional services.
4. **Ask for consent**: Ask the survivor if they give consent for you to contact other services and to pass their name. For non-specialized providers, this can be done verbally. A written document is not advisable, especially if confidentiality procedures are not known or cannot be followed. During case management, written consent should be obtained as much as possible
5. **Check limitations of consent**: After being made aware of any risks or implications of sharing information about their experiences, the survivor has the right to limit the information to be shared and to specify which organizations can and cannot be given the information.

Informed consent for child survivors

As a general principle, permission to proceed with assistance must be obtained from both the child and their caregiver unless it is deemed inappropriate to involve the caregiver.

Informed consent for survivors with disabilities

Gaining informed consent from persons with disabilities can sometimes be difficult, depending on the type and extent of their disabilities. The Convention on the Rights of Persons with Disabilities states that an individual cannot lose their legal capacity to make decisions simply because they have

a disability[37]. It is therefore vital to assume initially that all adult GBV survivors with disabilities can provide informed consent, and to follow the same previous procedures as described above. Some additions to these **procedures include:**

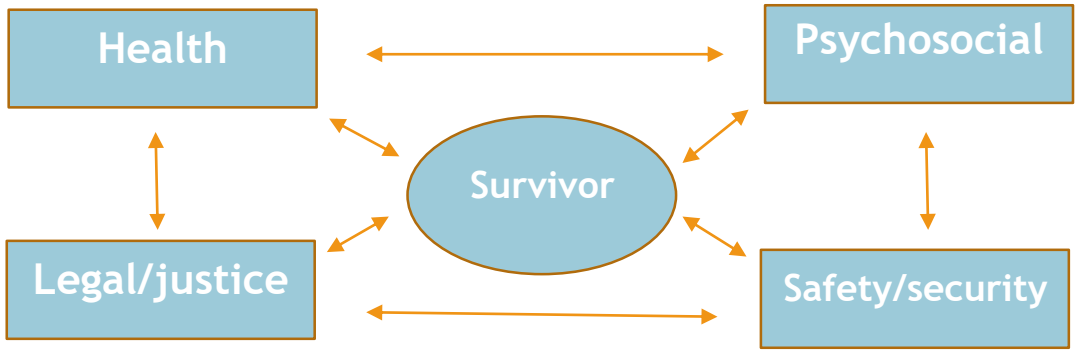
- Asking the survivor if they want some support to help them give informed consent.
- Adapting communication methods to match those preferred by and useful for the survivor.
- Allow enough time for questions to ensure the survivor understands everything, including the possible consequences of accessing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

2.3 REFERRAL

This chapter guides all actors on how to refer GBV survivors after disclosure. *(Refer to Annex 4: GBV Referral Pathways Template).*

GBV REFERRAL PATHWAYS TEMPLATE

The below figure presents the general "entry points" to core GBV services, including referrals. The multiple needs of survivors require coordination between service providers in a proper, integrated, and responsive manner.



Immediate response and referrals are considered necessary to enable GBV survivors' access to quality care promptly. Timely referrals could save lives and prevent additional harm and medical implications in some cases of sexual and physical violence.

In cases of sexual and physical violence, the priority should be to urgent healthcare due to the life-threatening nature of these incidents and the treatment related to certain diseases that could result from GBV. In these cases, the survivor should be encouraged to access healthcare, ideally within 72 hours of the incident. In cases of rape, the health protocol of the Ministry of Health, which is in line with the WHO guidelines on Clinical Management of Rape (CMR), should be applied. The response should include the provision of contraceptives and prevention of HIV and STDs.

Survivor referral options

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

[37] See http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

1. The survivor can contact or go directly to the GBV case management actor.
2. The actor can assist the survivor access the services by making a referral.

The choice of an option should always be made in consultation with the survivor. If they choose the first option, the role of the actor is to provide the survivor with information on where services are available. If they choose the second option, the actor should do this after obtaining the informed consent of the survivor and with full respect of the survivor's rights and dignity. They should contact the service provider's focal point and facilitate contact between the service provider and the survivor to arrange and follow up the care. Ask the survivor if they wish to be accompanied by somebody to the place they are referred to.

- After the actor has obtained informed verbal consent to make the referral to a GBV actor providing case management, and after the referral has been made, this is the end of responsibility for this actor. The responsibility for case management now rests with the GBV actor who has received the referral.
- Do not discuss sensitive information on the incident with any person except the focal point in the organization the survivor accepted to receive assistance from.
- In case that one or more services are not available or not accessible at a given time, it is important not to raise unrealistic expectations for a survivor about what services and support they may be able to receive.
- GBV survivors must never be forced or coerced into receiving support or services. The survivor has the right to refuse any support or service that is available or offered. The following are some guidelines for what to do when a survivor refuses a particular service:
    - ✓ Assure the survivor it is their right to refuse any service.
    - ✓ Explain to the survivor that their refusal right now does not affect in any way their right to request or access that service at any time in the future, and provide him/her with the details of the service providers in the area.
    - ✓ Confirm the survivor understands the consequences of not accessing the service.
    - ✓ Identify if any safety risks may be the reason the survivor has refused the service.
    - ✓ For GBV case management actors, and with the agreement and in consultation with the survivor, build a safety plan that includes identifying ways to eliminate or mitigate the risks of future GBV.
- GBV actors should develop functional referral pathways to ensure the provision of high-quality services to GBV survivors promptly. The GBV sub-sector plays a vital role in updating and disseminating the referral pathways.

Referral of children survivors of GBV

- Consideration should be given to the child-centered approach and the child's best interest in the short and long terms;
- The child should be involved in decisions related to referral;
- Information should be shared with the child and consent obtained in language and form suitable to the child's age and obtaining the formal consent of the guardian/caregiver;
- Children and guardians/caregivers should be informed of the mandatory reporting requirements;
- Children should be accompanied in all service provision locations within the route of referral;
- There may be cases where it is not appropriate to seek the consent of the guardian/caregiver, including when the guardian/ caregiver is the perpetrator or an

accomplice. In these cases, consent of another trust-worthy adult[38] whenever possible for children under 15 years. Children above 5 years must be consulted in choosing that person;

- Actors in the field of GBV and child protection should agree on the who is the focal point for receiving cases of referral f children survivors of GBV and provide case management to them. At the official level in Sudan, Family and Child Protection Units (FCPUs) are playing this role;
- According to Article (80) of the Child Act of 2010, there is a possibility for legal referral outside the justice system. The court may refer a juvenile case or delinquent children to be handled outside the justice system through an institution determined by the court, without court procedures in the Child Court first. The court must be committed to the description of the referral criterion and the elements of dealing with the case in these entities.

Referral of children with disability survivors of GBV

- Consent of the survivor with disability in a way suitable to his/her capacities and identifying a caregiver a trust-worthy person who knows how to communicate with persons with hearing/verbal/mental disability. If it is in the best interest of the survivor to get the consent of a family member or caregiver, this should be done.
- Ensure the understanding of survivors of all the information on available services and the benefits and risks associated with accessing services.

3.3 CASE MANAGEMENT

GBV case management

GBV case management is a structured method for providing support to a survivor. It involves one organization, usually psychosocial support (PSS) or social services actor, taking responsibility for making sure that survivors are informed of all the options available to them, and that issues and problems facing a survivor and their families are identified and followed up in a coordinated way, and providing the survivor with emotional support throughout the process[39]. The GBV case management has unique characteristics that distinguish it from other approaches to case management. It adopts the "survivor-centered" approach that aims to create a supportive environment in which each survivor's rights are respected and in which the person is treated with dignity and respect. **The survivor-centered approach recognized that every survivor:**

- Has equal rights to care and support.
- Is different and unique.
- Reacts differently to their experience of GBV.
- Has different strengths, capacities, resources and needs.
- Has the right, appropriate to their age and circumstances, to determine who should know what has happened to them and what should happen next.
- Should be believed and be treated with respect, kindness, and empathy.

The goal of GBV case management is to empower the survivors and, where appropriate their caregivers, by giving them increased awareness of choices they have in dealing with the problem and assisting them in making informed decisions about available services and what to do about the problem. Case management for GBV survivors is focused primarily on meeting the survivor's health, safety, psychosocial and legal needs following the incident(s).

[38] A trust-worthy adult is an adult relative or caregiver identified by the child.

[39] UNICEF. Communities Care Program: Transforming Lives and preventing Violence, (2014)

Basic principles that underpin case management include:

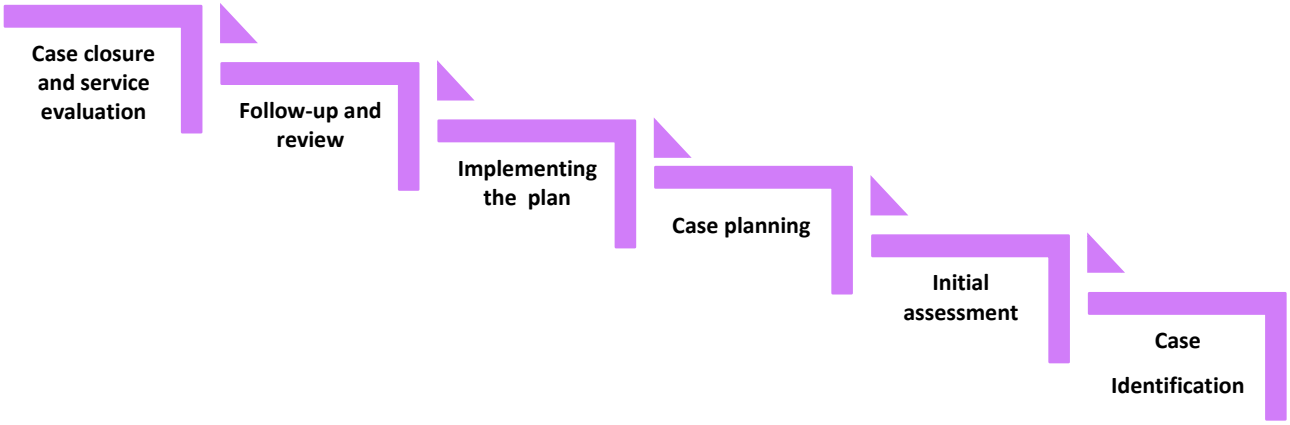
- Ensuring the survivor/child is the primary actor in case management and ensuring that they are involved in all aspects of the planning and service delivery;
- Respecting the wishes, the rights, dignity needs and capacity of the survivors, including children;
- Providing emotional support by demonstrating a caring attitude towards the survivor;
- Providing information to the survivor, including children, to allow them to make informed choices about services requested;
- Listening and establishing rapport and trusting relationship, which creates a supportive environment in which survivors, including children, can begin to heal;
- Ensuring confidentiality which is critical to protecting the survivor's safety and security and to prevent misuse of information;
- Ensuring non-discrimination by treating every survivor, including children, in a dignified manner irrespective of their gender, race, religion or circumstances of the incident(s);
- Obtaining informed consent from the survivor, including children, before sharing any information.

Steps of case management[40]:

- **Identification:** Case management always begins with disclosure and/or referral, including obtaining informed consent from the GBV survivor before starting the assessment, the referral, and any other actions on behalf of the survivor.
- **Initial assessment**: properly evaluate the safety and security of the survivor to identify if there is any risk to the survivor. The initial assessment also involves listening to the survivor's story, helping them identify needs without creating unachievable expectations. During the assessment, the case manager also evaluates the survivor's capacities and resources. The case manager and the survivor might identify supportive networks, including family members.
- **Case action planning:** To help a survivor plan how to meet their needs and improve their situation, the case manager should give relevant information about all services available without creating expectations that cannot be met. The case manager should help the survivor identify their options and help them make informed decisions about what they want to do. Developing a simple written action plan specifying what actions need to be taken, by whom and when and a timeframe should be agreed for the plan of action.
- **Implement the case action plan:** This step involves putting the agreed plan into action. This includes direct service delivery, making referrals to other services, and supporting the survivor throughout the process, including helping them access services. The case manager needs to be knowledgeable about GBV referral pathways. It is important to note that while the referred service (or agency) is responsible for providing specific service, the case manager maintains overall responsibility for following up on the case plan. All referrals should happen based on the informed consent of the survivor.
- **Follow-up and review**: This step involves following- up with the survivor and other services to make sure the survivor is getting the assistance and services they need. It also includes monitoring and evaluating that the survivor's medical and psychosocial needs have been met, and/or identifying with any barriers to achieving the action plan's outcomes. During the follow-up stage, the survivor, in consultation with the case manager, might identify additional needs and new action points which should be added to the case plan.

[40] Interagency GBV Case Management Guidelines: Providing Care and Case Management Services to GBV Survivors in Humanitarian Settings, (2017)

- **Case closure:** The survivor, in consultation with the case manager, decides when to close their case. The timing of the closure will depend on when the needs of the survivor have been met, and when the survivor is satisfied with the outcome of the healing process.
- **Service evaluation**: The case manager ensures the survivor's satisfaction with the received services and the outcomes of the healing process. The case manager carefully considers any feedback from the survivor for future improvement.



The case manager and organization guarantee the following throughout all the steps of the case management process:

- **Assess safety:** routinely carry out a thorough safety assessment to rule out potential abuse.
- **Maintain confidentiality:** If the survivor discloses information, they do not wish to be shared with their caregiver/ family members, you must respect and maintain the survivor's confidentiality. Do not share any of the survivor's information, even with the caregiver, without explicit permission from the survivor. All original documents must be saved in the secured and locked offices/rooms.
- **Focus on the survivor:** The survivor's will and preferences should guide all actions. Maintain primary communication and participation with the survivor, and ask for permission from the survivor to communicate with the caregiver or family member.
- **Support the caregiver:** If you determine that the caregiver or family member involved is safe, you should provide support to the caregiver as well. Providing them with accurate information about the risks and impacts GBV and trauma can help them understand what the survivor may be experiencing and how to support them best. Caregivers may be inclined to blame the survivor, so be sure to communicate that what happened was not the survivor's fault. Caregivers may also blame themselves for not being able to protect the survivor from violence. Providing messages to the caregiver that are supportive, non-blaming, and non-judgmental may be vital for them to hear. By supporting them, you are also enhancing their ability to support the survivor.

GBV case management with child survivors

Providing care for survivors of GBV who are children is particularly challenging. It requires qualified and trained staff with appropriate competencies and attitudes, working to clear guidelines. When dealing with child survivors of GBV, **case managers should:**

- Communication with child survivors of GBV using child-friendly techniques to encourage them to express themselves.
- Adaptation of steps and procedures of case management for children survivor of GBV. **This includes:**

- ✓ Apply the guiding principles in working with child survivors of GBV *(see chapter 2);*
- ✓ Implement procedures for obtaining informed consent;
- ✓ Evaluate immediate needs related to health and safety of survivors including psychological and legal needs and identifying early intervention services that protect the health and safety of the child;
- ✓ Continuous evaluation processes of children's safety in the family context and other social contexts after disclosing abuse;
- ✓ Action to be taken if there are suspicions that the perpetrator is a family or household member;
- ✓ Involve the non-offending guardian/ caregiver in all case management procedures;
- ✓ Any mandatory reporting laws relevant to acts of sexual violence against children, and procedures that will be taken with regard to those laws;
- ✓ Referrals to specific organizations skilled in working with child survivors;
- ✓ Appropriate communication with children with disabilities and their caregivers, including caregivers with disabilities.

GBV case management with survivors with disabilities survivors

When managing cases of GBV affecting persons with disabilities, it is essential to keep in mind the survivor may have communication and physical barriers that prevent them from clearly explaining what has happened and what they wish to access in terms of services and support[41].

The following points should be considered when managing cases of GBV involving persons with disabilities:

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

[41] Research from humanitarian contexts has demonstrated that the intersection of gender, disability and displacement increases the risk of violence for women, girls, boys and men with disabilities and their female caregivers. Women with physical disabilities who are isolated in their homes report rape and intimate partner violence. Women, girls, boys and men with intellectual and psychosocial disabilities are also more vulnerable to sexual violence in humanitarian contexts, due to a lack of information and awareness about GBV and gaps in protective peer networks. In addition, women and adolescent girls, who disproportionately assume caregiving roles in households with persons with disabilities, may be exposed to harassment and exploitation when seeking assistance or accessing income.

CHAPTER 4: GBV RESPONSE

4.1 HEALTH/MEDICAL CARE[42]

Health care providers play a crucial role in providing immediate and lifesaving care for GBV survivors. They provide treatment related to rape, sexual assault, and other types of GBV to prevent further harm and health consequences of GBV. Health care providers are committed to providing survivors of GBV with medical care as a priority. Access to health care will be provided in all cases, even before any other procedures.

Health care providers need to be familiar with the protocol relevant to the care of GBV survivors following internationally approved standards for the clinical management of rape (CMR) survivors. They should be trained on GBV core concepts, the Inter-Agency Standing Committee (IASC) GBV Guidelines (IASC 2015), and standards in the Clinical Management of Rape Guidelines (WHO/UNHCR 2004). They should also understand and inform GBV survivors about the importance of other potentially needed services, including legal and social services.

Health care providers will:

- Ensure the safety of the survivor and their family at all times;
- Ensure confidential, accessible, compassionate, and appropriate medical care for survivors of GBV;
- Provide the survivor with information about medical procedures;
- Obtain the informed consent of the survivor *(see the section on informed consent)*;
- Collect information in private settings;
- Ensure referral and follow up with other service providers according to the wishes of the survivor;
- Provide emotional support to the survivor in the medical institution or through referring survivors to quality services;
- Ensure documentation and follow up;
- Ensure medical services are accessible for survivors with disabilities and take into account their specific needs.

In cases of sexual violence, service providers offering medical care to GBV survivors that are signatory to these SOPs should implement the standards set out in the national health protocol of the Federal Ministry of Health. This protocol is based on the internationally recognized WHO guidelines[43] . It takes into account the legal amendment Number 6 of 2016 on survivors' right to receive medical care without the need to fill the Crime Documentation Form, known as Form (8)[44].

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

[42] Procedures in this chapter are quoted from reference evidence of GBV: Common Operational Procedures for GBV: Guiding Principles of SOPs, 2008> Subsidiary Working Group of the IASC on GBVK Salam Rotana Hotel, 17-18 July 2019 organized by the Unit of Combatting Violence against Women and Children and UNFPA.

[43] CMR: Protocols for use in dealing with refugees and migrants an updated copy of WHO/UNHCR, (2004).

[44]Prior to this amendment, a survivor had to obtain Form (8) from the Police before receiving medical care. The form takes the place of medical documentation for purposes of criminal prosecutions.

The following is a summary of the steps involved in the provision of CMR for women, men, boys and girls' survivors of sexual assault:

1. Prepare clinics to offer medical care for survivors of rape;
2. **Prepare the survivor for an examination:** Introduce yourself. Limit the number of people in the room to the minimum necessary. If the survivor wishes, ensure that a trained support person or trained health worker of the same gender accompanies the survivor throughout the examination. Ask if they also want to have a specific person present (e.g., family member or friend). Determine the best way to communicate and adapt to the survivor's communication skill level and language. Avoid medical terminology. Obtain informed consent (or guardians/caregivers' informed consent in the case of a child). Explain what is going to happen during each step of the examination, why it is essential, what it will tell you, and how it will influence the care you will give. Make sure the survivor understands everything. Reassure the survivor they are in control of the examination. Explain that they can refuse any aspect of the exam they do not wish to undergo and that this will not affect their access to treatment or care. Reassure the survivor that the examination findings will be kept confidential unless the survivor decides to bring criminal charges. Apply psychological first aid. Ask the survivor if they have any questions.
3. **Take the relevant medical history of the survivor:** If the history-taking is conducted in the treatment room, cover the medical instruments until they are needed. Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case. Avoid any distraction or interruption during the history-taking. Make sure the survivor feels comfortable. Use a calm tone and maintain eye contact. Be aware of the survivor's body language and your own. Be systematic. Proceed at the survivor's own pace. Be thorough, but do not force the survivor. Let the survivor tell their story the way they want to. Document the incident in the survivor's own words. Avoid questions that suggest blame. Be compassionate and non-judgmental. Explain what you are going to do at every step
4. **Collect forensic evidence:** The primary purpose of the examination of a rape survivor is to determine what medical care should be provided. If applicable, forensic evidence may also be collected to help the survivor pursue legal redress. The survivor may choose not to have evidence collected.
5. **Perform a physical examination:** The primary objective of the physical examination is determining what medical care should be provided to the survivor. Health care providers should be trained on Clinical Management of Rape. Make sure the equipment and supplies are prepared. Always look at the survivor first before you touch them, and take note of their appearance and mental state. Always tell the survivor what you are going to do and ask their permission before you do it. Conduct lab tests to ensure absence of STDs. Work systematically according to the medical examination form. If the survivor approves a pelvic exam, ensure the absence of internal injuries including fistula or rectum damage which requires urgent surgery. The health care provider performing the examination must be of the same gender as the survivor or according to the preference of the survivor. Use the survivor's history to guide the exam to prioritize the survivor's needs and wishes, to identify and document injuries, and to help guide follow-up care and referrals. Assure the survivor they are is in control, can ask questions, and can stop the examination at any time.
6. **Prescribing treatment:** What is prescribed will depend on when the survivor presents to the health facility, what the survivor experienced, and if the survivor is pregnant. Within 72 hours (3 days), the survivor receives medical treatment to prevent HIV transmission, receives preventive treatment for sexually transmitted infections (STIs/STDs), hepatitis B, and tetanus.

Within 120 hours (5 days) from the time of the assault, the risk of unwanted pregnancy may be reduced if the survivor receives the emergency contraception pill.
Provide information to the survivor on the consequences of GBV, particularly in cases of sexual assault, to assist them in understanding the reason behind the medical referral and to help them identify the kind of assistance they need and manage expectations. They must be informed that rape can lead to unwanted pregnancy, and that rape or attempted rape can expose them to HIV infection or STIs/STDs. Explain to the survivor that rape can lead to injuries and damage to genitals and that preventive medications and treatments are available but are time-sensitive. For example, STDs, such as chlamydia, gonorrhea, and syphilis should be treated with antibiotics as they could lead to infertility or other chronic diseases if not treated.

7. **Psychosocial first aid (PFA) and counseling:** Health care providers should offer all survivors of GBV psychosocial support, and it must be suitable to the gender, age and circumstances of the survivor. Health care providers must be trained on PFA. Counseling must take place from the first contact with the survivor, including counseling for specific issues such as pregnancy and STIs. Tell the survivor they can return to the health service at any time if they have questions or other health problems
8. **Medical certificates:** Medical care of a survivor of rape includes preparing a medical certificate/report to safeguard the legal rights of the survivor if they need to pursue legal action. It is the responsibility of the health care provider who examines the survivor to make sure the certificate/report is completed. Only the survivor has the right to decide whether and when to use this document. Maintain confidentiality and store all written information in a safe and secure location;
9. **Follow up care:** All survivors of GBV will benefit from follow-up medical and psychological care. Accompany the survivor if necessary.

Healthcare providers responding to GBV child survivor must have the knowledge, skills, attitudes, and tools to provide specialized medical care for child survivors, **including[45]:**

- Understanding child development and child sexual abuse concepts;
- Communicate effectively with child survivor;
- Understanding and ability to apply clinical care for child survivor;
- Adapting medical examination and treatment to meet the needs of child survivor;
- Ensuring safe and appropriate referrals and follow-up systems are in place.

Special considerations for children survivors of GBV

There are local protocols and legal procedures for the clinical management of child rape, **including:**

- Knowledge of specific local laws that determine who can give consent for minors. In Sudan, consent for medical examination and collection of forensic evidence must be obtained from one of the parents, the guardian, or caregivers.
- If the guardian/caregiver is the perpetrator, a representative of the Police or court may sign the consent form.
- Remember that a family member may be the perpetrator of the abuse. Always ask the child who he/she would like to be present during the interview or medical examination and respect his/her wishes.
- The child should never be examined against his will whatever his age unless there is a risk to his life;

[45] IRC and UNICEF. Caring for Child Survivors of Sexual Violence: Guiding Principle for Providers of Health, Psychological and Social Services in Emergency Situations, (2012)

- Never restrain or force a frightened, resistant child to complete an examination and do not respond in harmful ways to children's stress reactions (such as hitting, sarcasm, or belittling the child). Assure the child that he/she is not in trouble;
- Remind children often that they are safe, and they are not to blame.

The table below indicates the actors providing medical services for GBV survivors:

Service	Actor
Clinical Management of Rape for survivors of GBV	Hospitals and health facilities of the Ministry of Health

4.2 PSYCHOSOCIAL RESPONSE[46]

All actors in direct contact with survivors should be familiar with the guiding in "Chapter Two" of this document. They should be aware of their responsibility to listen carefully to the survivor and provide enough information on available services and provide the psychosocial support as indicated in the IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery (2015).

Providing emotional support:

- Prioritize safety at all times. There should be private space available for survivors to discuss their cases;
- Listen to the survivor and understand their feelings by asking only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press the survivor for more information than they are ready to provide;
- Effective and sensitive communication with survivors, mainly if they exhibit self-blaming. They should be provided with psychological support and assurance and affirming to them that sexual violence is always the fault of the perpetrator and never the fault of the survivor;
- Be mindful of your body language, facial expressions, tone of voice and maintain direct eye contact with the survivor;
- Provide honest and complete information about available services and facilities;
- Do not tell the survivor what to do or what choices to make. Instead, empower them by helping them to make informed decisions;
- Do not blame the survivor for the violence they experienced and do not tell them that they must immediately forgive the perpetrator.
- Use open questions when possible. An open question is one in which you allow space for the person to respond adequately (not just yes or no), thus giving the survivor the freedom to disclose as much as they feel comfortable at the time.
- Pay attention to warning signs indicating that the survivor has suicidal ideas that should be dealt with immediately and understand whether they are just ideas or if there is an intention to follow them through. This kind of evaluation requires intensive training and supervision, and if this experience is not available, the case should be referred to a specialized psychological service provider. Do not leave the survivor alone until they receive appropriate care.

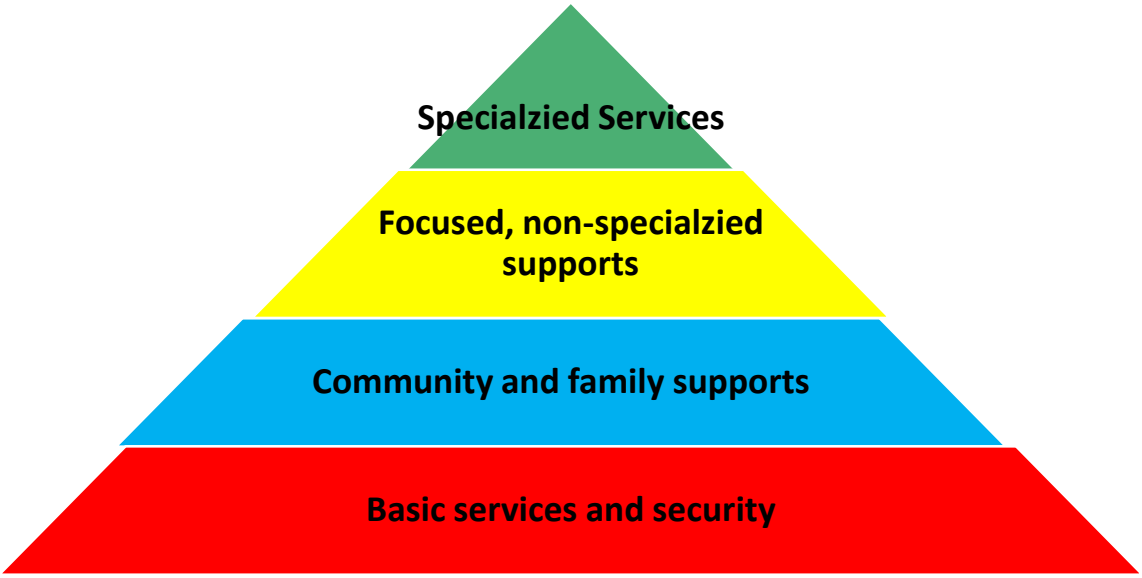
[46] The term "psychosocial" is used to underline the interaction between the psychological aspects of people and their environment or social context, and to recognize that mental health cannot be determined by the psychological aspects only but also by social factors . These factors affect each other.

Psychosocial support for survivors of GBV should be holistic. They should target both people and communities (or aspects of both). **Psychosocial interventions for survivors of GBV include the following inter-related types of activities:**

- Psychosocial support to assist with recovery and healing including psychological first aid (PFA), individual and group counseling;
- Support and assistance with social re-integration, including vocational training and women's empowerment, literacy training, school reintegration, Women and Girls Safe Spaces (WGSS), Child-Friendly Spaces;
- Mental health services for survivors who require/request specialized mental health support.
- Community awareness actions to reduce stigma and promote access to services for GBV survivors, strengthening of community and family support, including self-help and resilience initiatives.

Mental Health and Psychosocial Support Response (MHPSS)

Mental health and psychosocial support (MHPSS) indicates any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorders. According to the IASC Guidelines for MHPSS in Emergencies (2007), MPHSS interventions fall under four layers of interventions to meet the needs of GBV survivors. The figure below shows the layers of MHPSS.



Layer 1 - Basic services and security: The majority of people are represented in the bottom level of the pyramid. Most people recover their psychosocial wellbeing when basic physical safety is established, and they obtain social, material (food and NFIs), communal, and health services they need. The recommended way actors can intervene by ensuring that essential services and goods consider social and cultural factors and individual dignity and by consulting women and girls when planning a response. All actors must ensure their services reduce risks for women and girls.

Layer 2 – Community and family supports: A smaller but still substantial number of people require extra support from their community and families to recover their psychosocial wellbeing, as shown in the second lower level of the pyramid. Psychosocial support includes support provided by social networks and social re-integration including vocational training and women's empowerment, literacy training, school re-integration, child-friendly spaces and Women and Girls Safe Spaces

(WGSS), women's groups, youth clubs, recreational and creative activities (like in women centers) and other activities.

Layer 3 – Focused, non-specialized supports: A smaller number of people may need more focused services to regain their psychosocial wellbeing and protect their mental health, as shown in the third level of the pyramid. Such interventions include basic emotional and practical support, such as case management, in addition to psychological first aid (PFA), counseling for individuals and families, psycho-education about traumas, stress and emotional responses to conflict and displacement, and messages on positive coping and relaxation techniques.

Layer 4 - Specialized services: For a tiny percentage of people, the supports outlined above are not enough, and their mental health and ability to function productively depends on more specialized care. This level of support is devoted to individuals who suffer severe mental disorder and deep depression and cases of acute seriousness (harming self or others) in addition to persons who suffer underlying psychological problems. For these individuals, professional support is required from trained professionals, such as clinical psychologists, psychotherapists, and psychiatrists, who can provide more advanced mental health interventions. Interventions could include prescribing medications.

Referral to higher MHPSS care:

- GBV case management, when utilizing the survivor-centered approach, can be considered a form of MHPSS, falling under the third level of the pyramid: focused, non-specialized MHPSS. It is also an essential method for helping survivors access other mental health and psychosocial services, programs, and resources in their community that are part of the other layers of the MHPSS pyramid. For example, GBV case management services can help survivors access basic needs (Layer 1) as well as reconnect with family and community support systems (Layer 2). In situations where it is determined that a survivor requires a higher level of mental health care (Layer), GBV case management services can facilitate a survivor's access to such care[47].
- The vast majority of GBV cases can be managed successfully by a caseworker or social worker who provides basic psychosocial support and case management.
- Caseworkers and social workers should be supervised and supported in a regular and structured manner to ensure they maintain the skills and confidence to handle most cases of GBV.
- Referrals to practitioners in (Layer 4) Specialized Services should be made when:
  - ✓ Severe mental health conditions (psychosis, severe depression, etc.).
  - ✓ Cases with high risk (harm to self, to others), co-morbid with a medical condition,
  - ✓ Nonresponse to basic support for about four weeks.
  - ✓ History of psychiatric disorder or hospitalization in a psychiatric ward.
  - ✓ Being on psychiatric medications.
- Coordination between MHPSS actors should be made to ensure various MHPSS needs within different layers are met. For example:
  - ✓ Practitioners within (Layer 4) Specialized Services play a role in referring patients to other layers of the pyramid. For example, a caseworker can continue working with a client even while they are seeing a psychiatrist so that the caseworker can help them meet their other needs (e.g., shelter).
  - ✓ Referrals can also be made to other services within the same layer, depending on the needs and wishes of the client. For example, a GBV survivor can be referred from

[47] Interagency GBV Case Management Guidelines: Providing Care and Case Management Services to GBV Survivors in Humanitarian Settings, (2017)

individual counseling to group counseling offer by the same organization or another organization. A survivor can also be referred from one GBV casework to another organization's GBV caseworker (or Child Protection caseworker) if they are more comfortable with the other organization.

Psychosocial interventions for child survivors of GBV

Psychosocial interventions should be adapted for child survivors, and personnel providing support to child survivors should be trained accordingly. Psychosocial interventions for child survivors of GBV include **the following**:

- A comprehensive assessment to better understand the child's social and family environment, psychosocial wellbeing, and strengths to help determine the appropriate psychosocial interventions.
- Providing healing education, relaxation training, teaching coping skills, and problem-solving.
- Enhancing the wellbeing, safety, and comfort of children through the overall improvement of the recovery environment. This includes community awareness-raising activities to combat stigma and strengthen the possible access of GBV survivors to services and strengthening community and family support.
- Providing information to caregivers about the needs, care, and treatment of child survivors.
- Identifying and providing support for families at risk of child mistreatment.
- Facilitating groups for parents who have mistreated or are at risk of abusing their children.
- Providing psychosocial support services in all the layers of the MHPSSP, including the relevant specialized services.

The table below lists actors providing MHPSS services adapted explicitly to GBV survivors:

Service	Actor
Psychosocial support services for survivors of GBV	Ministry of labour and Social Development Ministry of Health

4.3 SECURITY/SAFETY RESPONSE

The safety of survivors should always be prioritized in integrated services for survivors of GBV. Case managers may, upon receiving a case:

- Work with survivors to find options and strategies that enable them to stay with their family or leave them according to the wishes of the survivors. Always prioritize safety;
- Provide phones or pre-paid cards so that the survivors may be in contact with the case manager in cases when the survivor is not reachable. This should only be done when it does not expose the survivor to additional risk;
- Provide the survivor with the hotline number (if available) to be used in cases of emergency.

The below table lists the primary safety and security, service providers:

Service	Actor
Police Protection	Police stations, Family and Child Protection Units (FCPU) UNHCR

Sudanese Police procedures:

The Sudanese Police procedures state the need to report the incident and to refer the survivor to medical care to prove the incident by filling the crime documentation form, known as Form (8), or the medical examination report.

4.4 LEGAL RESPONSE

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

- Information about existing measures that can prevent further harm by the alleged perpetrator;
- Information on available support in the event that legal proceedings are initiated, including legal aid and justice. For example, the legal Circular (6) affirms the right of the survivor to receive medical care without the Crime Documentation Form (form 8) and encourages the survivor to request assistance without fear of stigma. In 2015, Article (149) of the Sudan's Criminal Act was amended to clarify the difference between the crime of rape and other crimes and introduced a new text on sexual harassment in the Sudan's Criminal Act.
- Provide information on amendments related to services for child survivors of GBV. According to the Child Act of 2010 Article (45), there is now a child court. The punishment for child rape could be up to 20 years imprisonment and could reach capital punishment if the rape resulted in the death of the child. The judge in the Child Court must ascertain the presence of a social worker and ensure family and legal representation in court. There is now a hotline **(9696**) to receive reports and complaints on violations against children. FCPUs provide multi-sectoral services to children, including legal, psychological, social, and medical services.
- Information on court procedures, and any other issues of national justice mechanisms including the expected time frames;
- Information on the pros and cons of all existing legal options which include highlighting the inadequacy of any traditional justice solutions that do not meet international legal standards;
- Legal representation before the court if the survivor wishes to take legal redress;
- Wherever possible, legal actors and other actors providing support for survivors must cover all court-related costs and provide transportation to and from the courthouse when a survivor's case is being heard. The survivors should be informed of any cost implications from the beginning;
- Child survivors and their caregivers must be consulted on the option for legal justice and made aware of the available services and their limitations. The child's needs, wishes, and feelings must be taken into consideration, and every effort must be made to enable the child to express himself/herself and to take part in the decision-making process[48];
- Accompany the child to all court proceedings, including the pre-trial sessions, trial, and sentencing, and provide legal representation before the court.

The below table indicates key legal services:

Service	Actor
Legal advice Legal representation	Family and Child Protection Units (FCPU) for Child Survivors of GBV

Judicial procedures:

The Sudanese Justice System handles cases of GBV, whether perpetrated by a family member or non-family member following the Criminal Procedures Act of 1991. There is no specialized family

[48] IRC and UNICEF. Caring for Child Survivors of Sexual Violence: Guiding Principle for Providers of Health, Psychological and Social Services in Emergency Situations, (2012)

court to deal with such cases. The survivor can file a lawsuit in the Criminal Court and/or a divorce lawsuit in the Personal Status Court (Islamic *Shar'iya* Court). The Criminal Procedures Act of 1991 stipulates the protection of survivors during the hearings and protecting survivors from intimidating or harmful questions and/or language during the proceedings. It also prohibits items of obscene nature unless they relate to essential facts related to the case. The judge has discretionary authority to decide whether or not court proceedings can take place in private, and this is done on a case-by-case basis. Service providers should advocate for closed-door trials and sessions for all GBV survivors.

The judicial procedures are different for cases of sexual violence as the hearings are always held privately in the courtroom chambers. Extra protection and security measures are put in place during the hearing to ensure the safety of the survivor.

Judicial procedures related to children survivors of GBV
In 2007, the Ministry of Interior established the *Family and Child Protection Units (FCPUs)* in 17 states. There are now 63 units providing psychosocial support, health, and legal services to children. These units do not provide services to women survivors of GBV. The *Sudanese Child Act of 2010* stipulates child protection mechanisms, including hiring child prosecutors and establishing child courts.

When dealing with cases of child survivors of GBV

- Interviews with children can be recorded in the FCPU and used as evidence in court to spare the child from repeating details of the assault or going to the court;
- Hearings for children take place in private chambers, and privacy is ensured at all times;
- Trials should take place in the Child Court;
- The child must be consulted on the option for legal justice and made aware of the available services and limitations;
- The child's rights, needs, views, and feelings should be taken into consideration, and every effort should be made to enable the child to express himself/herself and participate in the decision-making process.

4.5 PROCEDURES FOR SPECIFIC GBV ISSUES

4.5.1 Child marriage

Article (18) of the Transitional Constitution protects children from child marriage, while the Personal Status law is not clear on the legal marriage age. Article (215) states that the age of maturity as 18 years but other articles allow the marriage of minors in some cases and Religious (*Shari'a*) judges allow the marriage on condition of the consent of the girl and her guardian/caregiver, and that marriage is in her best interest.

Upon receiving persons at risk of child marriage, service providers should apply the same case management procedures in accordance with other GBV cases *(see Chapter 3)*. **They also should:**

- Understand how the client feels about the marriage;
- Provide information on longer-term impacts of child marriage;
- If they consent, always giving priority to her/his safety, provide counseling to relevant family members to prevent child marriage.
- Ensure other referrals as guided by the wishes of the client.

Upon receiving cases of child marriage that have already occurred, the following services will be available:

- Legal assistance and representation following the family law;
- Provision of reproductive health counseling and services, including family planning;
- Access to educational and vocational training and referral;
- Advice and information on available psychosocial services, including Women and Girls Safe Spaces (WGSS), counseling and couple counseling, and referral if the beneficiary consents.

In cases where violence or other protection concerns are disclosed, follow the same procedures as for other GBV cases

4.5.2 Female Genital Mutilation/Cutting (FGM/C)

In 2016, the Council of Ministers of Sudan adopted a proposed amendment to the Criminal Procedures Law to criminalize FGM/C. Accordingly, the service providers should, upon receiving girls exposed to the risk of FGM/C, follow the same procedures of case management contained in Chapter 3 of this document. **They should also:**

- Advice clients on the legal, social and health consequences of FGM/C;
- If they consent, always giving priority to her/his safety, provide counseling to relevant family members to abandon FGN/C;
- Ensure other referrals as guided by the wishes of the client.

Upon receiving cases of FGM/C that already took place, the following services will be available:

- Legal assistance and representation;
- Provision of healthcare services;
- Advice and information on available psychosocial services, including counselling and referral services if the beneficiary consents.

In cases where violence or other protection concerns are disclosed, follow the same procedures as for other GBV cases

4.5.3 Sexual exploitation and abuse (SEA) involving UN and related personnel

Reporting and procedures are set down in the UN Secretary General's Bulletin on Sexual Exploitation and Abuse (2003) and are carried out in accordance with national laws[49]. SEA reporting is for all of UN organizations or organizations funded by the UN, and survivors must be informed that all information they disclose will be shared through appropriate mechanisms. PSEA mechanisms are currently being established in Sudan.

PSEA standards include:

- Sexual exploitation and abuse constitute acts of serious misconduct and grounds for disciplinary measures, including summary dismissal;
- Sexual activity with children is prohibited. Mistaken belief in the age of a child is not a defense;
- Exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading, or exploitative behavior, is prohibited. This includes any exchange of assistance that is due to the beneficiaries;
- Sexual relationships between UN staff or humanitarian workers are based on unequal power dynamics, undermine the credibility and integrity of the work of the agency, and are strongly discouraged.

[49] According to the UN Secretary General's Bulletin on "sexual exploitation": SEA means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Similarly, the term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions."

CHAPTER 5: GBV PREVENTION

5.1 GBV PREVENTION AND RISK MITIGATION

Several factors of GBV prevention and response are also considered preventive measures. In contrast, prevention activities are linked to the response procedures to GBV. It is necessary when planning prevention strategies not to limit the focus on the affected persons only, whether adults or children, but also to the community as a whole due to its role and impact on creating a culture of intolerance regarding GBV issues. The effect of GBV extends to cover other different systems. Without active prevention factors, the services provided cannot, on their own, produce the desired change in the attitudes and behaviors that cause GBV and child protection issues.

Although prevention and response are divided in this SOP into two separate sections, they are inter-related activities. Many elements of GBV and CP response are also preventive measures. Prevention entails working at different levels of society to achieve social change and implement targeted interventions with specific groups. Prevention also includes more generalized approaches for the population at large (e.g., campaigns, mass media messaging, and other awareness-raising initiatives). In setting prevention strategies, it is essential to target not only affected individuals (whether adults or children) but also the broader community, since the broader community is influential in creating a culture of non-tolerance for GBV and CP related issues. The impact of GBV and CP affects various systems, including physical and mental health, law enforcement, judicial and public social services, and non-profit organizations, as they respond to the incident and support children and/or survivors. Without a strong prevention component, service delivery alone will not change the attitudes and behaviors that cause GBV and CP and allow them to continue within the community.

All parties to these SOPs **will:**

1. Provide or participate in training about GBV, IASC GBV Guidelines, these SOPs, and other relevant materials, adapted to the sector on intervention ensuring the best recovery to survivors and reintegrating them in the community;
2. Adopt codes of conduct for all staff focusing on preventing sexual exploitation and abuse. Actions include: providing training to all the staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow up on reports;
3. Integrating GBV prevention concepts in educational curricula;
4. Promote gender equality and women's rights within family relations;
5. Develop the justice systems in the field of legislation and procedure to enhance the protection of women and facilitate survivors access to justice;
6. Strive to ensure active and equal participation of women, girls, boys, and men in the design and delivery of services and facilities, and meeting regularly with women and girls to learn about accessibility, safety, and security related to services and facilities.
7. Ensure services are inclusive and accessible for persons with disabilities;
8. Organize economic empowerment and capacity building activities to reduce vulnerabilities and exposure to risks,
9. Advocacy and coordination to develop awareness-raising activities on GBV and mobilize the support of various actors, including government entities, community leaders, religious leaders, and the media.
10. Ensure that public information messages, awareness-raising campaigns, and behavior change strategies are coherent, consistent, and connected to services and organizations to avoid confusion in the community;
11. Ensure services are inclusive and accessible for persons with disabilities;

12. Promote male role models and positive masculine norms and behaviors that are non-violent.
13. When designing projects and implementing interventions, always consider intended and not intended consequences of activities and review strategies to ensure survivors' protection and according to the best interests of the survivor(s);
14. Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as reflected in these SOPs and the IASC GBV Guidelines (2015) **including:**

- **Health:** Implement the Minimum Initial Service Package for reproductive health in emergencies (MISP); Ensure health services are accessible to women and children; Integrate GBV awareness-raising and behavior change activities into community health activities.
- **Social services/psychosocial services:** Influence changes in socio-cultural norms, promote respect for human rights and women's rights, encourage survivors to seek assistance, provide family counseling, promote community acceptance and social re-integration of GBV survivors.
- **Security:** Maintain sufficient security presence; through formal and informal networks, maintain awareness of protection and security issues related to GBV, provide information to the GBV sub-sector about protection and security issues, develop and strengthen specific prevention strategies to address emerging security issues.
- **Legal justice:** Raise awareness in the community on national laws and available legal aid services; promote respect for the survivor by the Criminal Justice System to encourage survivors to come forward to report violence; apply relevant laws and policies, and decide GBV cases effectively.

5.2 PREVENTION OF VIOLENCE AND ABUSE OF CHILDREN

All parties to these SOPs will:

1. Provide or participate in training about child protection, the Minimum Standards of Child Protection in Humanitarian Settings, these SOPs, and other relevant materials adapted to the sector of intervention;
2. Adopt codes of conduct for all staff focusing on preventing sexual exploitation and abuse. Procedures should include: training to all staff, requiring all staff to sign the code of conduct, establish safe and confidential reporting mechanisms and follow up on reports;
3. Actively seek equal participation of boys and girls in the design and delivery of services and facilitates and meeting regularly with girls and boys to learn about accessibility, safety, and security related to services and facilities as to strengthen the protective environment for children, by assessing and addressing protection issues;
4. Ensure inclusive and accessible services for children with disabilities and caregivers with disabilities;
5. Coordinate with the child protection sub-sector to develop and implement child protection awareness-raising activities within the community and advocacy among other actors and government authorities;
6. Work with various formal and informal community-based networks such as child protection committees to maintain awareness of child protection risks and issues, and communicate these to protection actors and the child protection and GBV sub-sectors, and ensure participation in discussions on problem-solving and strengthening of prevention strategies, strengthening respect for human and children's rights, and support the role of children as and youth as equal decision-makers;

7. Reinforce and activate the role of schools in implementing of extra-curricular activities to raise awareness on GBV through training of teachers and supervisors and strengthening cultural and artistic activities;
8. Reinforce the position of parents'/caregivers councils in schools;
9. Establish an attractive environment for children in neighborhoods under the supervision of families and community members;
10. Ensure all relevant sectors/actors are aware of and are carrying out their roles and responsibilities as described in these SOPs;
11. Raising community awareness on the rights of children without caregivers and unaccompanied children and designing special reintegration programs for them.

5.3 EXAMPLES OF GBV PREVENTION ACTIVITIES

1. Establishing Women and Girls Safe Spaces (WGSS), Child-Friendly Spaces and youth centers that provide multi-sectoral services;
2. Establishing community -protection committees, child protection committees and parent/caregiver-teachers' associations;
3. Implementing community awareness-raising activities;
4. Mobilizing religious leaders and community leaders to speak out on protection of women, men, and children;
5. Mobilizing men and boys to prevent violence;
6. Using arts, social media and mass media to raise awareness and encourage dialogue on prevention of violence;
7. Train volunteers on how to deal with GBV disclosures and on referral to specialized services.

CHAPTER 6:
INFORMATION DISSEMINATION

This chapter provides a quick overview of key considerations and principles for how information may be disseminated to the community as well as service providers. The chapter provides an overview of frequently used methods for information dissemination and suggested guidance on how and where the referral pathways can be disseminated.

It is essential to disseminate sufficient information on the main elements of the SOPs to enable GBV actors to perform their responsibilities and to facilitate survivors' access to services. **Therefore, it is essential to:**

- Ensure a coordinated approach and consistency of messages with other stakeholders carrying out information dissemination before conducting outreach activities related to protection;
- Develop a joint action bringing together all actors in these SOPs with prioritization of messages, timeline, scope and specific roles and responsibilities;
- Community awareness-raising interventions on available GBV services;
- Integrate special sessions on referral pathways and available GBV services into other related GBV training.

6.1 INFORMING THE COMMUNITY

The essential elements of these SOPs that should be shared with communities include:

- Where to go to obtain assistance if you are subjected to GBV;
- Roles and responsibilities of different actors in the field of prevention and response to GBV;
- Limitations and risks in accessing services;
- The GBV guiding principles;
- Message on survivors' security and confidentiality of information, particularly for sexual violence incidents, when accessing services.

6.2 INFORMING SERVICE PROVIDERS

In addition to ensuring that communities are regularly informed about services, it is equally as important to ensure that service providers are also aware and informed of available services. This includes service providers, GBV actors, women networks, and community protection networks, schools, religious and community leaders **through:**

- Presentation of these SOPs to senior management of participating organizations and formal endorsement and signature;
- Specific training to introduce or refresh knowledge of SOPs and referral pathways to GBV governmental, UN and NGO actors and the continuum of care and protection that links them;
- Training to introduce or refresh knowledge of SOPs and referral pathways to non-protection related governmental, UN and NGO actors from other sectors;
- Coordination meetings within and amongst, government entities, NGOs and UN agencies;
- Inter-agency case management training and other related capacity building initiatives;
- Develop a directory of all available institutions active in the health sector, psycho-social support, protection, security, and justice.

6.3 KEY MESSAGES ON GBV

- The root cause of GBV is gender inequality
- Knowledge of and access to GBV services can save lives
- Mutual support can help prevent GBV and ensure a good response to GBV

- Child marriage is a form of GBV
- FGM/C is a form of GBV and is classified as sexual violence as it is an assault that harms the health and dignity of girls and women and violates their rights
- Domestic/family violence is a form of GBV
- It is not shameful to discuss and report sexual violence
- The perpetrator and not the survivor is the one to blame.

6.4 INFORMATION DISSEMINATION METHODS

- Distribution of state and/or localities level GBV referral pathways with relevant information on services' locations, hours, and focal point contacts. The GBV referral pathways can be distributed through outreach and awareness-raising activities by mobile medical teams, youth programs, institutions, women centers/community centers, and Non Food Items (NFIs) or dignity kits distribution activities;
- Distribution of posters with key slogans and images or information regarding access to services;
- Radio/television information programs on available services and their importance;
- Dissemination of qualitative data (e.g., researches, assessments, safety audit results, situation analysis) to promote a better understating of GBV.

CHAPTER 7: COORDINATION

7.1 COORDINATION

Given its complexities, GBV is best addressed when multiple sectors, organizations, and disciplines work together to create and implement unified prevention and mitigation strategies[50]. Effective prevention and response to GBV require multi-sectoral coordinated actions among, at a minimum, health, psychosocial, justice and security sectors and the community. Non-protection agencies with a strong field presence also play a crucial role in reporting issues that come to their attention while undertaking non-protection specific activities.

The GBV sub-sector and the child protection sub-sector work closely with the Unit for Combating Violence Against Women and Children to strengthen GBV prevention and response in Sudan. The GBV and Child Protection sub-sectors collaborate and harmonize interventions on overlapping issues, such as sexual abuse on children.

The GBV sub-sector works to facilitate multi-sectoral, inter-agency actions aimed at preventing GBV and ensuring accessible, timely, and survivor-centered GBV response services. UNFPA chairs the GBV sub-sector. Members include UN agencies, national and international NGOs, organizations involved in GBV prevention and response or child protection, or other relevant sectors. Organizations wishing to join the GBV sub-sector will follow the procedure highlighted in the sub-sector Terms of Reference (ToR).

The GBV sub-sector meets monthly in Khartoum and states-level, where it is present. Extraordinary meetings and ad-hoc task forces are created by the chair and at the request of the members when it is necessary to address an issue of an urgent matter. The GBV sub-sectors at the states-level have specific tasks and responsibilities outlined in their TORs.

Information is shared at least monthly between members of the GBV sub-sector through the dissemination of meeting minutes. Issues needing action from other sectors are identified in these minutes. The GBV sub-sector also reports regularly to the protection sector. The GBV referral pathways will be updated on a regular and ad hoc basis.

All other sectors (such as health, education, protection, etc.) are encouraged to be represented by technical staff in the GBV sub-sector. They are also encouraged to coordinate with the GBV sub-sector and the relevant coordination bodies. GBV focal points can ensure the integration of protection principles and GBV risk-reduction strategies into ongoing programming.

[50] IASC. Guidelines for integrating gender-based violence interventions in humanitarian action: Reducing risk, promoting resilience and aiding recovery, (2015)

SIGNATORY PAGE FOR PARTICIPATING ACTORS

We, the undersigned, as representatives of our respective organizations, agree and commit to:

- Abiding by the procedures and guidelines contained in this document;
- Fulfilling our roles and responsibilities to prevent and respond to GBV;
- Providing copies of this document to all incoming staff in our organizations with responsibilities for action to address GBV, so that these procedures will continue beyond the contract term of any individual staff member.

UNFPA Representative	**Ministry of Labour and Social Development**
Date:	**Date:**
Signature	**Signature:**
Institution:	**Institution:**
Date:	**Date:**
Signature	**Signature**
Institution:	**Institution:**
Date:	**Date:**
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Signature	**Signature**

ANNEXES

ANNEXES

- Annex (1): International and regional Conventions and instruments ratified by the Republic of the Sudan

- Annex (2): WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies

- Annex (3): Sample Sexual Exploitation and Abuse Code of Conduct

- Annex (4): GBV Referrals Pathways Template

ANNEX 1: INTERNATIONAL AND REGIONAL CONVENTIONS AND INSTRUMENTS RATIFIED BY THE REPUBLIC OF SUDAN

These SOPs have been developed based on international and regional instruments ratified by the Republic of Sudan, including:

- The Universal Declaration of Human Rights (UDHR) (1948);
- The Supplementary Convention on the Abolition of Slavery, the Slave Trade, and Institutions and Practice Similar to Slavery. (1956).
- The Abolition of Forced Labour Convention (1957);
- The International Convention on the Eradication of all Forms of Racial Discrimination (1965);
- The International Covenant on Economic, Social and Cultural Rights (ICESCR) (1966);
- The Convention Relating to the Status of Refugees (1951) and its 1969 Protocol;
- The OAU Convention covering the Specific Aspects of Refugee Problems in Africa (1969);
- Sudan signed but did not ratify the Protocol to the Africa Charter on Human and Peoples' Rights on the Rights of Women (the Maputo Protocol) (1981);
- The Arab Charter on the Rights of the Child (1984);
- The Optional Protocol to the Convection on the Rights of the Child on the Involvement of Children in Armed Conflicts (2000);
- The African Charter on the Rights and Welfare of the Child (the ACRWC Children's Charter) (1991);
- Sudan is committed on the Vienna Declaration on the Elimination of Violence against Women (1993);
- The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children supplementing the UN Convention against Transnational Organized Crime and the optional protocols (2000);
- The United Nations Convention against Transnational Organized Crime and the optional protocols (2004);
- Convention on the Rights of Persons with Disability (CRPD) and the Optional protocol of 2006.

National laws related to these SOPs:

- The Personal Status law Act of 1991;
- The Sudan Criminal Act of 1991, Amendment 2015;
- Interim National Constitution (2005);
- The Minister of Justice Circular number (2) of 2004 that allowed sexual assault survivors to receive medical treatment without Form 8;
- The Sudanese Armed Forces Act (2007);
- The Child Act (2010)
- Criminal Circular Number 4 of 2011 related to severe punishments of crimes committed against children
- The Sudan Asylum Act (2014);
- The Combatting of Human Trafficking Act (2014);
- The Minister of Justice's Circular Number (6) of 2016 on the dissemination of Circular (2) of 2004 to all states of Sudan.

Policy framework

The state is taking steps to protect women and to achieve gender equality, particularly in civil, political, and cultural rights and the right to healthcare, property, and education.

Main national policies related to gender equality include:

- The National Policy for the Eradication of FGM/C in One Generation (2008 – 2018).
- The National Quarter-Century Strategy (2007 – 2031) on Gender Equality and Women Empowerment.

- The National policy for the Empowerment of Women adopted by the Council of Ministers in 2007.
- The National Plan to Combat Gender-Based Violence
- The National Policy on Girls' Education 2007

A draft national policy to combat violence against women and girls for the period 2019 – 2031 was prepared. Issues of gender equality are integrated into the sectoral plans of Ministries of Health, Justice, Foreign Affairs, Labour, Education, Agriculture, Finance, and industry, in addition to CBS. The Directorate of Women and Family Affairs of the Ministry of Welfare and Social Security is entrusted with drawing up policies under the umbrella of the Ministry of Labour and Social Development.

A National Committee for Women Development was established in accordance with the Ministerial Decision Number 12 of 2003. The committee comprises 45 members from all women-relevant sectors and institutions and NGOs. The committee is chaired by the Minister of Welfare and Social Security and is entrusted with proposing general policies and drafting legislation for empowering women. The committee supervises the design and review of national policies for women empowerment as an advisory body that also evaluates achievements realized within the national, regional, and international commitments.

ANNEX 2: WHO ETHICAL AND SAFETY RECOMMENDATIONS FOR RESEARCHING, DOCUMENTING AND MONITORING SEXUAL VIOLENCE IN EMERGENCIES

The eight safety and ethical recommendations addressed here are:

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

ANNEX 3: SAMPLE SEXUAL EXPLOITATION AND ABUSE CODE OF CONDUCT

Code of Conduct for Sexual exploitation and abuse

All actors involved in the prevention of and response to GBV should understand and sign a Code of Conduct or a similar document, setting out professional standards of conduct. Humanitarian agencies have a duty of care to beneficiaries and a responsibility to ensure that beneficiaries are treated with dignity and respect and that specific minimum standards of behavior are observed.

In order to prevent sexual exploitation and abuse, the following core principles must be incorporated into the humanitarian agency code of conduct:

- Sexual exploitation and abuse by humanitarian workers constitute acts of misconduct and are therefore grounds for termination of employment.
- Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of maturity or age of consent locally. Mistaken belief in the age of a child is not a defense.
- Exchange of money, benefits, employment, goods, or services of sex, including sexual favors or other forms of humiliating, degrading, or exploitative behavior, is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- Sexual relationships between humanitarian workers and beneficiaries as strongly discouraged since they are based on inherently unequal power dynamics. Such relationships undermine the credibility and integrity of humanitarian aid work.
- Where a humanitarian worker develops concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, she/he must report such concerns via established agency reporting mechanisms.
- Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their code of conduct. Managers at all level have particular responsibilities to support and develop systems which maintain this environment.

To ensure the maximum effectiveness of the Code of Conduct, it should be posted in clear view in the public areas of each actor's office/center, introduced and explained, signed by all staff and kept in employee files. All posted and distributed copies of the Code of Conduct should be translated into the appropriate language of use for the field areas.

RESOURCES:

Secretary-General's Bulletin on "Special measures for protection from sexual exploitation and sexual abuse" (ST/SGB/2003/13): http://www.pseataskforce.org/uploads/tools/1327932869.pdf

Examples of Codes of Conduct: http://www.pseataskforce.org/en/tools

Annex 4: GBV REFERRAL PATHWAYS TEMPLATE

GBV referral Pathways
State XX, Locality XX
Latest update: dd-mm-yy

Basic instructions:

- Protect the survivor's identity and the confidentiality and safety of personal data.
- Treat the survivor with respect and ensure that all discussions take place in a secure place with a staff of the same gender.
- Do not share data of survivor with any person/party without consent.
- Provide reliable and comprehensive information on the available services and support to survivors of GBV.
- Be patient and a good listener, and do not judge/blame, pressure the survivor to obtain unnecessary information.
- Ask relevant questions only.
- It is not part of your job to investigate the case. The priority is that the survivor receives immediate care and the necessary support.
- If the survivor does not wish to report to the police, refer him/her to medical care and do not report to the police. If the survivor wishes to resort to legal recourse, there should be a medical certificate/report acceptable to the court.
- Ensure consulting the child survivor and involving him/her in a decision affecting their lives.
- When family/guardians decide 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.

In case different services providers are available in the location where the survivor was identified, choose the one that is most accessible and convenient for the survivor. In case no service is available in the location where the survivor was identified, please consider the nearest or the most accessible. Distance from the service provider should not be a reason for not referring. Consider that many service providers offer mobile services or can provide transportation. Make sure that you refer all cases.

TELLING SOMEONE AND SEEKING HELP (DISCLOSING)	
Survivor tells about the GBV incident to family, friend(s), community member, general service provider; that person receiving the report should inform the survivor of the available services and accompany the survivor to health or case manager/psychosocial "entry point" upon his/her consent.	Survivor self-reports a GBV incident 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 GBV and inform them of the benefits and risks of accessing these services;
- If agreed and requested by the survivor, obtain informed consent, and proceed with the referral.
- 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 hours) access to medical care
- Remember: **Recent sexual violence is a medical emergency**

Medical/Healthcare as entry point to services		Case management including immediate psychosocial support (entry point to services)	
Medical/health facilities Contact person: Phone Number: Address:		**Case management service providers – adults (above 18)** Contact person: Phone Number: Address:	**Case management service providers - children (under 18)** Contact person: Phone Number: Address:
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 survivors to police/security – or – to legal assistance/protection officers			
Protection, Security, Police		**Justice/legal services**	
Police stations and Family and Child Protection Units (FCPUs) Contact person: Phone Number: Address:		**Legal assistance service providers** Contact person: Phone Number: Address:	
After immediate response, follow-up and refer to other available services based on survivor's choices Additional services can include any of the following			
Long term healthcare (e.g., reproductive health)	**Psychosocial Services**	**Protection and child protection services, Security, and Justice**	**Basic services (Cash, NFI, Dignity Kits etc.)**
Health centers Contact person: Phone Number: Address:	**Social centers/ women centers/ community centers/ Women and Girls Friendly Spaces (WGSS)/ Child Friendly Spaces** Contact person: Phone Number: Address:	**Organization:** Contact person: Phone Number: Address:	**Organization:** Contact person: Phone Number: Address:

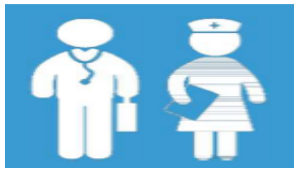


The survivor will report to someone that they trust



The individual or agency they trust will accompany them to the nearest health facility upon obtaining their consent

Cash Support
Education
WGSS
Safe Spaces



Emergency contraceptives
STIs
PEP
Medical Exam

Legal Assistance

If the survivor wishes to pursue the case judicially





Case management and psychological support



Police/protection/security

If the survivor wishes to report incident

Medical Follow-up