Movimiento por la Paz

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AJUNTAMENT DE VALÈNCIA

HANDBOOK ON SEXUAL AND GENDER BASED VIOLENCE AGAINST PEOPLE WITH DISABILITIES

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INTRODUCTION

1. Context in Lebanon and Jordan

Information about Movement for Peace in Lebanon

Movement for Peace - MPDL is a Spanish non-governmental organization working on Development Cooperation, Social Action and Humanitarian Aid. Created in 1983, it aims to contribute to world peace by fostering cooperation, solidarity and understanding between people. With almost 35 years of experience, Movement for Peace has developed cooperation projects in several countries, including by carrying out initiatives that seek to support organizational processes and strengthen civil society by promoting a culture of peace. Movement for Peace's strategic framework focuses on providing access to human rights and the community-based rehabilitation (CBR) methodology, which Movement for Peace has been using in the region since it began its work in the late 1990s in Palestine, Jordan, and Lebanon.

In Lebanon, Movement for Peace has been working since 1993. It was initially active in a wide range of social and human rights issues. Later, it broadened its scope to provide development and humanitarian assistance, mainly targeting Palestinians and the Lebanese hosting community. At the beginning of the 21st century, Movement for Peace emerged as one of the main actors working on disability in Lebanon, with a long-standing history of funding and support from important donors like ECHO and the Spanish cooperation Agency in Lebanon. Movement for Peace's strategy on disability in Lebanon has been to provide holistic services to people affected by any type of disability, focusing on issues such as promoting inclusive development and advocating for their rights, as well as integrating the services already provided by UNRWA or other NGOs to address these persons' needs.

Disability is not, however, the only issue covered by Movement for Peace, which has been active in the fields of women's rights and empowerment, and youth empowerment, while working towards strengthening civil society by all means. For this reason, Movement for Peace has created an extensive network involving local authorities, ministries, and several local partners all over the country.

Regarding Gender Based Violence (GBV) and Sexual and Gender Based Violence (SGBV), Movement for Peace started addressing this issue in 2016 by launching a first small project, "**Improving the protection system and resilience of the vulnerable Syrian population: women and PWD"**. This project was implemented together with its local partner Lebanese Union for People with Physical Disability (LUPD) and funded by "Ayuntamiento de Valencia".

Within this framework, Movement for Peace has highlighted the need for guidelines that will improve the capacity of its staff and its partner organizations to identify and deal with cases of GBV perpetrated against People with Disabilities (PWD). Additionally, such guidelines will contribute to promote and improve access to an early warning system to identify and prevent any type of gender-based violence against them. The response to GBV cases has become one of the main areas of intervention of Movement for Peace and is addressed through all the projects that are currently being implemented or will be implemented in the future.

The present Standard Operational Procedures are intended to be a working tool for Movement for Peace's staff and its partner organizations, based on the information obtained through a needs assessment and a training process. Information about Movement for Peace in Jordan

Movement for Peace is a non-governmental organization of Development Cooperation, Social Action and Humanitarian Aid, created in 1983 and whose objective is to work for world peace by fostering cooperation, solidarity and understanding between people and peoples. With almost 35 years of experience, this organization has been developing development projects in many countries, including initiatives that seek the support of organizational processes and the strengthening of the civil society of these peoples from a culture of peace. The Movement for Peace strategic framework is based on access to human rights and the CBR methodology (community-based rehabilitation) that Movement for Peace has used in the region since it began its work in the late nineties in Palestine, Jordan and Lebanon.

Movement for Peace has been working in Jordan since 1994, carrying out development projects in the following sectors:

- Defending and promoting women's rights
- Strengthening civil society and democratic governance
- Improving the living conditions of people with disabilities

Since 2014, Movement for Peace has been implementing a protection project in Madaba supporting Syrian refugees with disabilities. Movement for Peace, in collaboration with its local partners, will contribute to the protection of persons with disabilities in some of the regions where the displaced population from Syria is currently present due to the humanitarian crisis, namely Amman, Mafraq, Zarqa, and Madaba. In particular, the project envisages the creation and establishment of Disability Safe Spaces, which will carry out various activities, including rehabilitation, psychosocial support, and informal education activities. It also involves the development of specific protocols and tools for the staff in the centers to be able to identify and deal with SGBV survivors or persons at risk of SGBV, especially children, youth and women with disabilities displaced from Syria.

The purpose and scope of the Movement for Peace Standard Operational Procedures

According to the 2011 WHO World Report on Disability, more than a billion people in the world (about 15% of the world´s population) are affected by some form of disability. People with disabilities generally have poorer health, lower education achievements, fewer economic opportunities and higher rates of poverty than people without disabilities. The prevalence of disabilities in women is higher than in men: while only 12 per cent of men have a disability, when it comes to women the figure reaches 19 per cent.[1]

[1] WHO and World Bank, *World Report on Disability* (Geneva, WHO, 2011), 28.

In 2015, the number of women and girls with disabilities was estimated at 700 million globally.[2] The intersection of the factors of inequality mentioned above and gender inequality makes women and girls with disability one of the most vulnerable and marginalized groups of society.

In situations of crisis, people with disabilities are among the most vulnerable and socially excluded groups. They may experience difficulties in accessing humanitarian assistance programs, due to a variety of societal, environmental and communication barriers, increasing their protection risks, including the exposure to Gender Based Violence (GBV). For women and girls with disabilities, the intersection of gender inequality and disability makes them especially vulnerable to GBV and increases the likelihood of their experiencing higher levels of physical, sexual and psychological violence. In addition, social norms often designate women and girls to be caregivers.

Persons with disabilities and caregivers, particularly women and girls, in recognition of their higher exposure to violence, have a right to protection in situations of humanitarian crisis, and should be able to access services and participate in GBV programs on an equal basis with others.

According to the research "Hidden victims of the Syrian crisis: disabled, injured and older refugees", 30 per cent of refugees have specific needs: one out of five refugees is affected by physical, sensorial, or intellectual impairment; one out of seven is affected by chronic disease; and one out of 20 suffers from injuries, with nearly 80 per cent of these injuries resulting directly from the conflict[3].

2. The need for a GBV guide

The response to cases of GBV targeting PWD, specifically women and girls, follows the same procedures then in cases involving persons without disabilities. In general, women and girls encounter many barriers hindering their access to services and rights.

Tackling violence against women and girls with disabilities requires a global response. It means rigorously researching best practices, as well as evidencing the scale of the problem and how disability and gender intersect.

[2] Estimate based on two reports: Department of Economic and Social Affairs, *World population prospects: 2017 revision*, in which it is estimated that the global female population is approximately 3.6 billion, and *The World Report on Disability*.

[3] 2014 HelpAge International and Handicap International

Against this background and with the aim of improving the response to GBV and applying a multisectoral approach, Movement for Peace has developed with Alianza por la Solidaridad a handbook about the process that has to be followed in order to identify the gaps in the services provision and the needs of women, children and people with disabilities in general suffering Sexual and Gender Based Violence. This process has taken place in the Disability Safe Spaces, a space dedicated to detecting and providing quality first care to GBV cases, which might be then referred to other service providers. The project has been developed in collaboration with the centers of Movement for Peace and their partner organizations in Jordan and Lebanon.

Target group

The main groups targeted by the services are minors and people with disabilities (refugees or Jordanian children and adolescents in a vulnerable situation).

Who works in the Safe Spaces?

This guide has been created especially for the staff working in the Movement for Peace centers and their local partners' centers, namely:

- Center Coordinators
- Physical therapists
- Occupational therapists
- Special Educators
- Speech Therapists
- Case managers also providing psychological support
- Social and field workers

Needs assessment process

During the needs assessment process conducted in the CBR centers in Jordan and Lebanon, it was found that people with disabilities and women suffer from GBV and stigma situations. Women are exposed to several types of sexual, physical, and domestic violence, as well as sexual harassment and sexual exploitation, while children with disabilities might be subjected to various forms of violence. In addition, persons with disabilities have to face increased stress within their families, the community perception that persons with disabilities are unable to physically defend themselves, and the stigma. The lack of knowledge about GBV, combined with the absence of specialized services and the gaps in the referral system, further increases the vulnerability of women and children with disabilities.

Preventive and awareness programs involving the community were identified as a need, while the staff needs specific training and support concerning detection, basic help, and referral pathways in GBV cases.

Main findings:

- Regarding the care services, it was found that also women with disabilities go to these centers, mostly to receive rehabilitation services, but no preventive or awareness programs targeting them or their families are in place.
- The need for the staff to better understand the concept of Gender Based Violence.
- The need to enable the staff to recognize signs and indicators of Gender Based Violence against persons with disabilities.
- The need to design and implement Gender Based Violence prevention programs, such as community awareness workshops, awareness sessions for children on different aspects of protection, making women aware of their rights and creating youth and community initiatives.
- The importance of mapping both governmental and non-governmental service providers and signing memorandums of understanding with them to facilitate the referral and provide better services to the beneficiaries.
- The need to know and apply basic guidelines when dealing with cases of Gender Based Violence against people with disabilities.

CHAPTER 1: DEFINITIONS AND KEY TERMS

1. Basic approaches to work on GBV with PWD

Gender approach

Adopting a gender-sensitive approach means questioning the unequal relationship between women and men, recognising that they do not enjoy the same opportunities or rights, and trying to make a change. The gender approach allows us to question masculinity and femininity as natural categories, understanding that the set of characteristics, roles and values attributed to women and men in a given society are social constructions, which not only determine the way in which they relate to each other, but also the distribution of power between them and their access to and control of all kinds of resources and opportunities. Sexual differences form the basis of in-built social inequalities, and these inequalities constitute a human rights issue.

Gender interacts with multiple categories of discrimination, socially and culturally constructed, such as ethnic and cultural origin, age, class, sexual identity and option, physical abilities, etc., in such a way that the situation and position of a person is influenced by multiple factors that interrelate and that vary according to society, context, culture, etc. The integration of the gender approach in the work in favor of women's rights implies recognizing and seeing reality from a perspective that makes visible, questions, and transforms power relations between women and men, as well as the multiple forms of discrimination and exclusion that condition women's participation and exercise of their rights.

Human Rights approach

Human rights are universal, inalienable, indivisible, interconnected and, interdependent.

Everyone is entitled to all rights and freedoms, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The equal and inalienable rights of all human beings provide the foundation for freedom, justice and peace in the world, according to the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948.

The human rights-based approach focuses on those who are most marginalized, excluded or discriminated. This often requires an analysis of gender norms, different forms of discrimination and power imbalances, to ensure that the interventions reach the most marginalized segments of the population.

In the frame of the Human Rights approach, it is important to take into consideration International Human Rights Law, which sets out the rights of all persons and applies both in peacetime and during conflicts.

2. Specific approach to work with people with disabilities

Community-based rehabilitation (CBR)

Community-based rehabilitation (CBR) was initiated by the World Health Organization (WHO) following the Declaration of Alma-Ata in 1978. It was promoted as a strategy to improve access to rehabilitation services for people with disabilities in low-income and middle-income countries, by making optimum use of local resources. Over the past 30 years, thanks to a collaboration with other UN organizations, nongovernmental organizations and disabled people's organizations, CBR has evolved into a multisectoral strategy to address the broader needs of people with disabilities, ensuring their participation and inclusion in society and enhancing their quality of life.

This approach has a strong focus on empowerment, facilitating the inclusion and participation of disabled people, their family members, and the communities in all development and decision-making processes. The present guidelines also recommend that CBR programmes be evaluated and further research be carried out on the effectiveness and efficiency of CBR in different contexts.

Inclusive models in disability

There are many ways in which society may view or interact with persons with disabilities, that can result in their exclusion or inclusion.

The inclusion model is supposed to use a **social or rights-based approach**:

- **Social model**: People look at the barriers that exist in the community and remove them so that people with disabilities can participate on an equal footing with others.
- **Rights-based model**: Persons with disabilities have the right to enjoy equal opportunities and participation in society. We all have the responsibility to promote, protect and ensure that this right is respected, and persons with disabilities should be able to claim these rights.

The social and rights-based model has provided a powerful framework for mobilizing persons with disabilities around the idea that they should be actors in their own lives, rather than passive recipients of care. This approach is essential to work on GBV prevention.

3. Legal frameworks

It is important to be aware of and take into account the specific legal frameworks pertaining to women, children and people with disabilities.

With the adoption of the 2030 Agenda for Sustainable Development, the international community made an implicit commitment towards the empowerment and advancement of women and girls with disabilities. On the principle of "leaving no one behind", the 2030 Agenda explicitly recognizes gender equality and disability as cross-cutting issues.

a. Women with Disabilities' rights

Women's rights are fundamental human rights. were enshrined in the United Nation's Universal Declaration on Human Rights. These rights include **the right to live a like free from violence**, slavery, and discrimination; to be educated; to own property; to vote; and to earn a fair and equal wage.

As the now-famous saying goes, "women's rights are human rights." Women are entitled to all of these rights. Yet, almost everywhere around the world, women and girls are still denied them, often simply because of their gender.

Jordan and Lebanon have signed the CEDAW Convention, which provides a comprehensive legal framework for fighting discrimination based on gender and defines violence against women as **"any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life."**

The rights of women and persons with disabilities are rooted in the Charter of the United Nations and the Universal Declaration of Human Rights and further supported by several international instruments, norms and standards on human rights, development, disability, gender and, more recently, peace and security[4].

The needs and role of women with disabilities were addressed explicitly by the World Program of Action concerning Disabled Persons, adopted in 1982, which recognized women with disabilities as a special group and addressed the specific barriers they face in accessing health care, education and employment.

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly in 1993, also called for particular attention to be paid to women when working on achieving equality of opportunities for persons with disabilities. The Beijing Declaration and Platform for Action, adopted in 1995, further outlined specific actions that Governments should take to ensure the empowerment of women and girls with disabilities in various areas, thus including the issue of disability inclusion into the general efforts to address the multiple barriers to empowerment and advancement faced by women and girls.

In Jordan, persons with disabilities are protected from violence under article 30, which states that:

An act of violence (in relation to persons with disabilities) is defined as any act or omission that will deprive a person with disability of a certain right or freedom, or one that will restrict his/her practice of either his/her rights or freedom, or will undermine his/her physical integrity, or will inflict mental and/or psychological harm to the person with disability on the basis of, or because of, his/her disability.

[4] Health and Human Right Info.

The Convention on the Rights of Persons with Disabilities clearly states at article 6 (Women with disabilities) that:

1. States Parties recognize that women and girls with disabilities are subject to multiple discriminations, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.

2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention

3.2 Child Protection

Convention on the Rights of the Child

The standards for Child Protection are grounded in the international legal framework outlined above. Child Protection is defined as the prevention of, and response to abuse, neglect, exploitation and violence against children. Thus, child protection is not the protection of all children´s rights but refers instead to a subset of these rights. The Convention on the Rights of the Child was the first instrument to incorporate the complete range of human rights— including civil, cultural, economic, political and social rights - as well as aspects of humanitarian law and remains the most important human rights legislation addressing children's rights signed in the world[5]. However, children around the world are still deprived of their most basic rights.

The Convention on the Rights of the Child sets out the **four principles below, all of which are relevant to humanitarian action:**

- Survival and Development

  As well as children's right to life, humanitarian workers must consider the effects of the emergency and the response on the physical, psychological, emotional, social, and spiritual development of children.

- Non- Discrimination

[5] https://www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf

Emergencies often magnify the existing differences and further marginalize those already at risk of discrimination. Humanitarian workers must identify and monitor both the already existing and the emerging patterns of discrimination and power and address them within the response.

- Child Participation

Humanitarian workers must ensure that girls and boys are given space and time to meaningfully participate at all possible stages of an emergency preparedness and response program. Boys and girls of different ages and abilities, and with different perspectives, should be treated with respect and taken seriously. Humanitarian workers must be aware of their own values, beliefs and assumptions about childhood and the roles of the child and the family, and avoid imposing these on children. They should enable the appropriate ways of child participation, involve children in decision making, and be sensitive about how children's participation may, if poorly done, jeopardize children's social roles and power relations.

- The Best Interest of the Child

In all actions concerning children, the best interests of the child shall be a primary consideration. This principle should guide the design, monitoring, and adjustment of all humanitarian programmes and interventions. Where humanitarian workers take decisions regarding individual children, previously agreed procedural safeguards should be implemented to ensure this principle is upheld.

The Convention on the Rights of the Child (CRC) affirms that all children are entitled to protection from all forms of violence. This principle is further reinforced by the Convention on the Rights of Persons with Disabilities (CRPD), which introduces specific measures in recognition of the fact that women and girls with disabilities are often at greater risk of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation. The Convention on the Rights of Persons with Disabilities clearly states, under articles 7 and 16, that:

Article 7: Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.

2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.

3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to provide with disability and age-appropriate assistance to realize that right.

Article 16: Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.

2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and, takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

4. Specific definitions of People with disabilities

a. Definitions from UN and the Jordanian Law

Disability arises when a health condition interacts with societal barriers that make it difficult to perform everyday activities and participate in the community life in the same way as others do.

"Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others." (Convention on the Rights of Persons with Disabilities, 2006)

According to the Jordanian Law on the Rights of Persons with Disabilities, a person with disability is defined as: “any person suffering from a permanent, partial or total impairment affecting any of their senses or their physical, psychological or mental capabilities, to an extent that undermines their ability to learn, work, or be rehabilitated and in a way which renders them unable to meet their normal day-to-day requirements under circumstances similar to those of non-disabled persons”.

b. Types of disabilities

There are different kinds of disabilities. Some disabilities are obvious, like not being able to walk and thus using a wheelchair, and some are invisible, like mental disabilities or hearing impairments. Some people have more than one type of disability.

Disability categories:

- **Physical, motor disability**: it covers all the disorders that can cause partial or total mobility impairment, including those affecting the upper and/or lower body (walking difficulties, difficulty in maintaining or changing position, in manipulating objects or performing certain actions). Some impairments of cerebral origin can also hinder expression in the absence of damage to intellectual abilities.[6]
- **Sensory disability**: it’s an impairment that affects one or more senses (sight, hearing, smell, touch, taste or spatial awareness). The most common are the visual disabilities (limitation of one or more functions of the eye or visual system) and the hearing disabilities (limitation of one or more functions of the auditive system, which in some cases can lead to a difficulty in expressing concepts orally)
- **Intellectual disability**: it refers to a difficulty in understanding and a limitation in the speed of mental functions in terms of comprehension, knowledge and perception. Related disabilities occur to different degrees and can be disruptive of the processes of knowledge retention, attention, communication, social and professional autonomy, emotional stability and behavior.

5. Specific definitions related to Gender Based Violence

a. Difference between gender and sex

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[7].

[6] http://www.hiproweb.org/fileadmin/cdroms/Handicap_Developpement/www/en_page31.html

[7] IASC

Sex: Refers to the physical/biological differences between males and females. It is determined by biology and does not change.

It is important not to confuse Gender with Sex.

Gender (man / woman)	**Sex (male/ female)**
Cultural traits, ascribed to women and men by a particular culture, alongside the values, roles and relationships that define such characteristics, Cultural, political, economic and social roles of women and men, which are deeply rooted in the customs, traditions and different community institutions	Biological traits
It is learned and built by males and females at different stages of life	It is biologically determined: people born as males and females
Changing and different from one place to another, from one culture to another, from one period to another.It can therefore be changed	Non-changing and constant (woman's ability to reproduce, the presence of uterus, differences in the reproductive system between males and females)
Not common among all women or all men, and sometimes it differs within the same community among different classes	Global, with males sharing the same traits worldwide, and females sharing the same traits around the world

Gender and Gender Identity:

While gender refers to the roles, behaviors, activities, and attributes that a given society at a given time considers appropriate for men and women, gender identity refers to the people's internal experience, preferences, and naming of their gender. Gender identity can correspond to or differ from the commonly understood gender norms associated with the sex we are assigned at birth. The two gender identities most people are familiar with are boy and girl (or man and woman), and often people think that these are the only two gender identities. This idea that there are only two genders–and that each individual must be either one or the other–is called the "Gender binary." However, throughout human history we know that many societies have seen, and continue to see, gender as a spectrum, and not limited to just two possibilities. In addition to these two identities, other identities are now commonplace.[8]

[8] https://www.genderspectrum.org/quick-links/understanding-gender/

b. **Gender-based violence (GBV)**

i. Definition

GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females. The nature and extent of specific types of GBV vary across cultures, countries, and regions. Women and girls are the 'primary victims of GBV', which makes it crucial to focus on strategies for addressing violence against women and girls.

Common Types of GBV [3]

TYPE OF GBV	DEFINITION/ DESCRIPTION *
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 includes marital rape and anal rape/sodomy.
Sexual Assault	Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks.
Sexual Exploitation	The term "sexual exploitation" means any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of "forced prostitution" can also fall under this category. [2]
Sexual Abuse	The term "sexual abuse" means the actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions. [3]
Physical Assault	An act of physical violence that is not sexual in nature. Example include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.
Domestic Violence/ Intimate Partner Violence	Violence that takes place between intimate partners (spouses, boyfriend/girlfriend) as well as between other family members. This type of violence may include physical, sexual and/or psychological abuse, as well as the denial of resources, opportunities or services. [4]
Forced Marriage & Early Marriage	The marriage of an individual against her or his will. Early marriage (marriage under the age of legal consent) is a form of forced marriage as the girls are not legally competent to agree to such unions). [5]
Psychological/ Emotional Abuse	Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc. "Sexual harassment" is included in this category of GBV.
Denial of Resources, Opportunities or Services	Denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. "Economic abuse" is included in this category. Some acts of confinement may also fall under this category.

TYPE OF GBV	DEFINITION/DESCRIPTION*
Trafficking in Persons	"...the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."
Harmful Traditional Practices	Cultural, social and religious customs and traditions that can be harmful to a person's mental or physical health. It is often used in the context of female genital circumcision/mutilation or early/forced marriage. Other harmful traditional practices affecting children include binding, scarring, burning, branding, violent initiation rites, fattening, forced marriage, so-called "honour" crimes and dowry-related violence, exorcism, or "witchcraft".
Sex-selective Abortion/ Female Infanticide	Sex selection can take place before a pregnancy is established, during pregnancy through prenatal sex detection and selective abortion, or following birth through infanticide or child neglect. Sex selection is sometimes used for family balancing purposes but far more typically occurs because of a systematic preference for boys.
Son Preference	"Son preference refers to a whole range of values and attitudes which are manifested in many different practices, the common feature of which is a preference for the male child, often with concomitant daughter neglect. It may mean that a female child is disadvantaged from birth; it may determine the quality and quantity of parental care and the extent of investment in her development; and it may lead to acute discrimination, particularly in settings where resources are scarce. Although neglect is the rule, in extreme cases son preference may lead to selective abortion or female infanticide."
*Please note: the definitions provided here refer to commonly accepted international standards. Local and national legal systems may define these terms differently and/or may have other legally-recognized forms of GBV that are not universally accepted as GBV.	

(Curriculum Guide for Managing Gender-based Violence Programs in Humanitarian Settings, which build on the GBVIMS. UNFPA.)

GBV results from **power inequalities that are based on gender roles**. Around the world, gender-based violence almost always has a greater negative impact on women and girls. For this reason, the term "Gender-based Violence" is often used interchangeably with the term "Violence against Women" (VAW). GBV is a phenomenon present in all cultures.

If we cross gender and disabilities with power, inequalities acquire a double dimension. The social construction of male and female roles and the social norms established make being a woman or a girl with any kind of disability a risk and a vulnerability factor.

Power can be “real” or “perceived” and it is defined by social and cultural inequality structures that discriminate women and PWD.

In this sense, applying a social and Human Rights approach ine PWD Services is fundamental to guarantee thatpeople and women with disability are empowered and enhance their ability to get away from violence.

6. Other relevant definitions and terms[9]

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

Community: the term is used to refer to populations affected by an emergency, including refugees and hosting populations.

Confidentiality: an ethical principle associated with medical and social service professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client’s case with his/her explicit permission. All written information is kept in locked files and only non-identifying information is written down on case files. Maintaining confidentiality about abuse also means that service providers never discuss case details with their family or friends, or with colleagues whose knowledge of the abuse is deemed unnecessary. There are limits to confidentiality while working with children.

Informed consent: the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give his/her consent. Parents/caregivers are typically responsible for giving consent for their children to receive services until the child reaches 18 years of age. In Jordan, adolescents aged 16 years and above are also legally able to provide consent in lieu of their parents/caregivers.
Consent means saying “yes,” agreeing to something. Informed consent requiresan informed choice, made freely and voluntarily by persons enjoying an equal power relationship. Acts of gender-based violence occur in the absence of informed consent.

Informed assent: it means the expressed willingness to participate in services. For younger children, who are by definition too young to give informed consent but old enough to understand and agree to

[9] GBV Standard Operational Procedures. (Jordan and Lebanon)

participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services.

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

Disability Safe Space: A Space satisfying all requirements to ensure that persons with disabilities are not subjected to violence, abuse or neglect and providing the various facilities they need to access services without any risk, while ensuring an environment that promotes their autonomy and their inclusion into society.

Psychosocial support: Support aimed to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder.

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

Survivor/victim: person who has experienced gender-based violence. In Jordan "victim" is a term often used in the social and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency (see IASC GBV Guidelines). In Lebanon the term victim could only be used to refer to the survivor in legal terms/procedures. The term "victim" is defined by the National Framework for Family Protection as "the person or persons exposed to violence in the family, either directly or indirectly."

The services response must take into account the meaning of the words, but the most important thing is to understand how to avoid further victimizing survivors. In this sense, gender- and human rights-approaches are essential to guarantee a quality response.

CHAPTER 2: CAUSES AND CONSEQUENCES OF GENDER BASED VIOLENCE AGAINST PERSONS WITH DISABILITIES

1. Context

GBV IS CAUSED BY GENDER INEQUALITY AND ABUSE OF POWER. Anyone can experience GBV, including men and sexual and gender minorities. At the same time, **women are disproportionately affected by male violence as a means to subordinate, dis-empower, punish or control them**. The gender of the perpetrator and the survivor are central not only to the motivation of violence, but also to the ways in which society condones or responds to such violence. In situations of crisis and displacement, people with disabilities suffer from a triple vulnerability, as disability intersects with gender.

Violence against women is a structural and widespread problem. Despite the fact that a comprehensive international legal framework exists, it remains necessary to change cultural and social norms and behaviors regarding gender inequality.

A CONTRIBUTING FACTOR is something that makes a problem worse. Factors that contribute to GBV vary according to the setting, population and type of GBV. There are many situations that can worsen GBV, especially in emergencies. Violence is often used as a means to force a person into his or her stereotyped and defined social role, as well as maintain an unequal social order that puts women in a situation of inferiority and devalues what is considered feminine.

Gender inequality is based on the power imbalance between men and women and is exacerbated by the inequalities, oppression and abuse of power associated with disability.

2. Main causes

The root causes of GBV against persons with disabilities are the same as for other people:

- Abuse of power
- Inequality
- Disrespect

For many women and girls, the violence they experience because of their gender intersects with other inequalities. Thiese include the oppression inflicted by majority populations against others based on race, religion, age, class, sexual orientation and disability, all of which contribute to the further marginalization of women and girls with disabilities, as well as in their loss of power and status in their relationships, households, and community..

Most women and girls with disabilities have experienced a long history of discrimination and disempowerment by family members, caregivers, partners and even service providers, as well as at a

more general level by community and culture. People with recent disabilities may face changes in relation to their independence, decision-making ability and status in their relationships, households and communities.

Gender Based Violence also includes violence perpetrated against lesbian, gay, bisexual, transgender and intersex (LGBTI) persons that is, according to OHCHR, "driven by a desire to punish those seen as defying gender norms" (OHCHR, 2011).

The acronym 'LGBTI' encompasses a wide range of identities that share the experience of falling outside of societal norms due to their sexual orientation and/or gender identity. OHCHR further recognizes that "lesbians and transgender women are at particular risk because of gender inequality and power relations within families and wider society." Homophobia and transphobia not only contribute to this violence but also significantly undermine LGBTI survivors' ability to access support (most acutely in settings where sexual orientation and gender identity are policed by the State).[10]

As service providers, we must work with women, girls, and all survivors with disabilities to support them to develop their "power within" and obtain the "power to" make their own decisions about services and assistance. Service providers must be careful not to reinforce negative and harmful power dynamics between persons with disabilities and others and/or exercise "power over" these individuals in the design or implementation of programs which might affect their self-esteem, generating psychological problems that increase the incidence of GBV.

Scenario: how to empower the disabled people to take their own decisions [11]

"My daughter with intellectual disabilities is safer if she stays inside the house. So I don't let her go out – I keep the door locked."

— Mother of a girl with intellectual disabilities

In this scenario, the mother has the power. Sometimes, parents, families and communities take actions based on the charitable model of disability. Although they believe they are acting in the best interest of the child, this approach may rather reduce the persons with disabilities' access to the same opportunities as the other children.

It is therefore imperative to engage with family members to explore the interests of the child, while at the same time addressing their concerns about safety in the community. In this way, it is possible to foster healthier power interactions between the mother and her daughter.

[10] https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

[11] file:///C:/Users/gts/Downloads/GBV-Against-Children-and-Youth-with-Disabilities-Toolkit.pdf

Women, girls, boys and men with disabilities and their caregivers who have been displaced due to crisis and conflict experience multiple, intersecting and sometimes mutually reinforcing forms of discrimination and oppression, increasing their risk to be exposed to violence, including GBV. In the case of women and girls, crisis situations exacerbate and heighten the risks they already face in times of peace. When this intersects with disability-related discrimination and oppression and with the demands of caregiving, the violence to which that women and girls are exposed is even greater. Approaching GBV through an intersectional analysis helps us to better understand the multiple identities and experiences of persons with disabilities, including inequality and discrimination between men and women, as well as within subsets of men and women, which may uniquely shape the way they experience GBV. This new understanding can in turn be used to improve service provision, advocacy and program priorities.

As stated in the CRPD (Convention on the Rights of Persons with Disabilities), disability is the result of intersections between impairments and other barriers in society. Persons with disabilities are not more vulnerable to violence because of their impairment, but rather because they are perceived as different, have less power and status, are marginalized and are even directly targeted for violence.

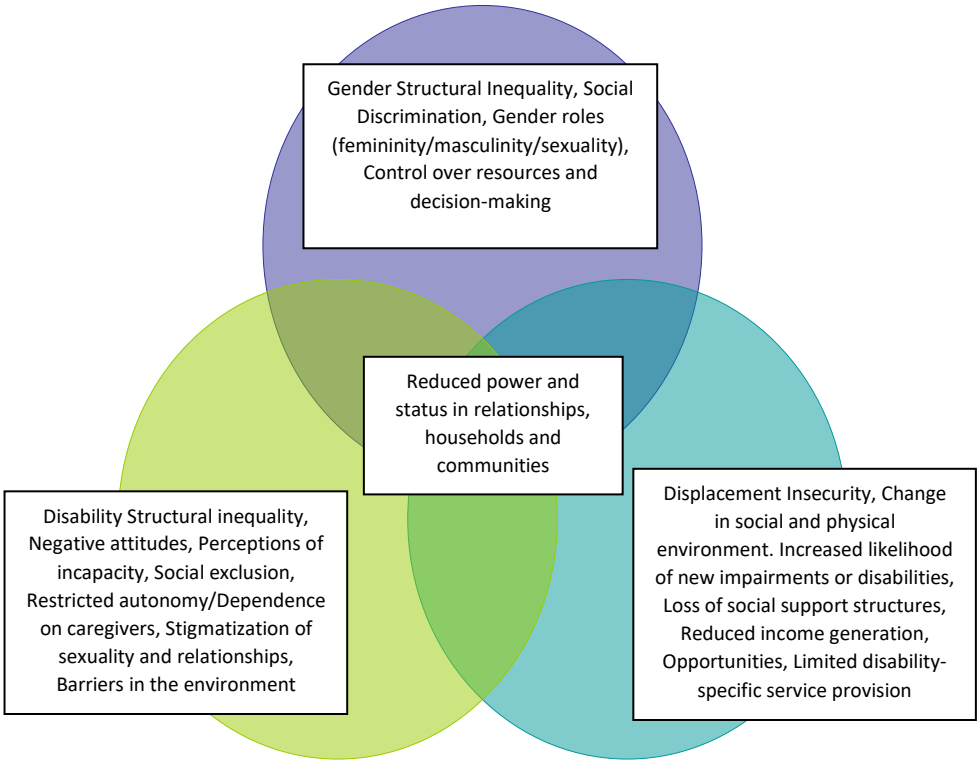
In 2015, the Women's Refugee Committee published the report "Building Capacity for Disability Inclusion in Gender-based Violence (GBV) Programming in Humanitarian Settings". This project seeks not only to understand the individual vulnerability to GBV, but also how relationship, community and societal factors relating to both gender and disability in the context of displacement increase the risk of violence for women, girls, boys and men with disabilities and their caregivers.[12]

Among the main findings was the fact that abuse perpetrated by strangers against adolescents (girls and boys alike) with intellectual disabilities was reported in Jordan, leading some caregivers of young persons with disabilities to lock them inside the home to protect them from further violence.

The most common type of sexual violence reported in urban centers in Jordan was sexual harassment and exploitation by male community members targeting the wives of men with disabilities when they moved around the community unaccompanied by a man, since women going out alone was not considered an appropriate behavior.

[12] https://www.womensrefugeecommission.org/resources/document/945-building-capacity-for-disability-inclusion-in-gender-based-violence-gbv-programming-in-humanitaria

Power and Equality — Examples of the intersection between gender, disability and displacement



3. Factors related to disability that may increase vulnerability

Stigma and discrimination: Persons with disabilities experience negative attitudes in their communities, which leads to multiple levels of discrimination and greater vulnerability to violence, abuse and exploitation, especially for women and girls with disabilities. It may also reduce their participation in community activities that promote protection, social support and empowerment.

Perceptions about capacities of persons with disabilities: Perpetrators perceive that persons with disabilities will be unable to physically defend themselves or effectively report incidents of violence, which increases their probability of being a target for violence. This is particularly true for women and girls with physical disabilities and persons with intellectual disabilities, who encounter a number of barriers in reporting violence and/or negotiating sex in an abusive relationship. People may not listen to or believe them, especially when it comes to a survivor with mental or intellectual disabilities, which reduces their access to services. It is often assumed that persons with disabilities do not understand what happened to them or are not able to express their needs, thus contributing to the impunity enjoyed by perpetrators of such violence.

Loss of community support structures and protection mechanisms: This is particularly severe in contexts of recent displacement where families and communities have already been separated. In general, women and girls with disabilities are often rejected or isolated from others because of their disability. Some families may resort to tying up their disabled relatives and/or locking them inside the house to prevent them from moving around the community, where they fear they may experience violence, although this behavior might also be caused by a sense of shame due to cultural and community norms. Adolescent girls with disabilities may also be excluded from protective peer networks, programs and denied access to education, which could otherwise serve to strengthen their capacities and support their transition into adulthood.

Extreme poverty and lack of basic supplies: The lack of income or basic supplies increases the risk that women and girls with disabilities may be abused and exploited, including by service providers or community members. It could also increase the risk of abuse and exploitation perpetrated by partners, while reducing the person's ability to leave violent relationships due to their dependence on others.

***Environmental barriers and lack of transportation/accessibility*:** Persons with disabilities must rely on other community members to access services and assistance, which increases the risk of exploitation and abuse and makes it difficult to access GBV response services in a confidential way. For this reason, it is important in the centers to make cases detection and referrals in a way that guarantees the confidentiality when accessing GBV attention services.

Isolation and lack of community support: This increases women with disabilities' risk and vulnerability to violence, particularly inside the house. Some persons with disabilities may be locked in the house and hidden by family members, while others find it difficult to go outside and meet other people. A lack of community support and friendships can mean that they do not acquire the information and skills they need or have people to go to when they experience violence. It also means that violence is often perpetrated in private, with few options to report it or seek outside assistance.

Lack of information, knowledge and skills: Women and girls with disabilities often have little information about GBV and personal safety, which means that they are less able to protect themselves. This is particularly true for women and girls with intellectual disabilities, who may be more easily targeted by perpetrators. Persons with disabilities are also consistently excluded from all programs and activities, and information is usually not conveyed in a way that they can understand, making it more difficult for them to seek assistance.

Lack of sexuality knowledge**:** Most people experience sexual feelings, needs, and desires, regardless of their abilities. Nevertheless, many young people, including those with disabilities, receive little or no sexual health education, either in school or at home. Thus, manifesting sexual behavior openly may expose them to a higher risk of sexual violence and abuse than other persons, especially given their specific situation, as they cannot protect themselves and face a lot of challenges when seeking assistance.

4.Consequences of gender-based violence

GBV may cause a number of medical, psychological, and social consequences, which vary depending on the types of GBV.

- Death, through either homicide or suicide, is not uncommon.
- The most significant social outcome is the stigma, combined with the general tendency of society to blame the victim for incidents of GBV, especially in case of rape and other sexual abuses. The stigma and the blame result in even greater psychological and emotional suffering for the survivor and often influence the behaviour of those who are supposed to help him/her.
- The survivor may be considered as an outcast in the community and even deemed not suitable for marriage.
- Survivors of GBV are at high risk of further abuse and victimization.

- **Health consequences**: All types of sexual and gender-based violence have serious and potentially life-threatening consequences on the survivor's health, which vary depending on the type of GBV.

Individual consequences for the survivors:

Fatal Outcomes:

Homicide • Suicide • Maternal mortality • Infant mortality • AIDS-related mortality

Acute Physical Consequences:

Injury • Shock • Disease • Infection

Chronic Physical Consequences:

Disability • Somatic complaints • Chronic infections • Chronic pain • Gastrointestinal problems • Eating disorders • Sleep disorders • Alcohol/drug abuse

Reproductive Consequences:

Miscarriage • Unwanted pregnancy • Unsafe abortion • Sexually-transmitted infections (STIs), including HIV/AIDS • Menstrual disorders • Pregnancy complications; infertility • Gynaecological disorders • Sexual disorders

Impact on wider society:

Strain on medical system

- **Psychological/Emotional Consequences**: Most psychological and emotional aftereffects should be viewed as normal human responses to horrific, terrifying, extreme event. In some cases, however, the survivor experiences mental illness that requires medical intervention.
- ***Individual consequences for the survivors:***

  Post-traumatic stress

  Depression

  Anxiety, fear

  Anger

  Shame, insecurity, self-hate, self-blame

  Mental illness

  Suicidal thoughts, behaviour, attempts

  Impact on wider society:

  Significant strain on the resources of the community, family, neighbours, friends, service agencies, schools, social and community leaders, etc.

  Survivors are unable make their contribution to society, for example by taking care of children and earning an income. If the perpetrators are not apprehended and arrested, this sends a strong message that this kind of behaviour is somehow acceptable, leading to further incidents of violence.

- **Legal/Justice System**: Lack of access to legal system, lack of knowledge of the existing laws, confusion regarding the most appropriate channels, i.e. criminal, traditional etc. The survivors are reluctant to report the incident due to the heavy stigma attached to sexual abuse. Strain on the resources of the already overburdened police and justice system. Lack of sensitivity to the issues expressed by judges. Significant costs incurred by the survivor.
- **Social Consequences**:

  Most societies tend to blame the survivor for the incident, especially in cases of rape. This social rejection results in further emotional damage, including shame, self-hate and depression. Due to their fear of social stigma and rejection, most survivors never report the incident, thus never receiving proper health care and emotional support. Most incidents of GBV are never reported to anyone.

  Blaming the victim

  Loss of ability to function in community (e.g., earn income, care for children)

  Social stigma

  Social rejection and isolation

  Rejection by husband and family[13][14]

Consequences of GBV against women and girls with disabilities [15]

1. **Homelessness**

   Women with disabilities who have experienced violence are at increased risk of homelessness. When women with disabilities attempt to flee the abusive situation (or are forced to leave the home of the abuser as another form of abuse), they often lose their home and, as shelters are often inaccessible, they have no alternative than living in the street. In many cases, the social isolation imposed by the abuser during the abuse causes women with disabilities to sever relationships with families, friends and other support networks that could help in such situations.
2. **Poverty and Unemployment**

   Women with disabilities who have experienced violence are at increased risk of poverty and unemployment. For example, the abuser may harass or intimidate them

[13] http://gadguatemala.weebly.com/uploads/3/7/5/2/3752316/tot_gender-based_violence.pdf

[14] https://www.scribd.com/document/133262265/Training-Manual-Interagency-Multisectoral-Prevention-and-Response-to-Gender-based-Violence-in-Populations-Affected-by-Armed-Conflict-Beth-Vann-RHR

[15] https://womenenabled.org/pdfs/Ortoleva%20Stephanie%20%20Lewis%20Hope%20et%20al%20Forgotten%20Sisters%20-%20A%20Report%20on%20ViolenceAgainst%20Women%20%20Girls%20with%20Dis

in the workplace, harass other employees or prevent them from going to work at all as a mechanism of control, causing them to lose their job.

3. **Disability, illness and injury**

   Violence against women with disabilities often aggravates existing disabilities and causes additional disabilities, as violence itself can lead to disability among women who previously did not have any. Disabilities include both the physical injuries resulting from violence as well as the psycho-social conditions that stem from ongoing isolation, abuse, demeaning conduct and other aspects of violence against women.

4. **Health effects**

   Violence causes adverse health consequences both in the immediate and in the long term, including injuries, physical and mental health concerns, substance abuse, and sometimes even death. Gender based, domestic, and sexual violence can all lead to disability due to sexual injuries, as well as increase the risk of contracting sexually transmitted diseases such as HIV/AIDS.

5. **Pregnancy-related impacts**

   For women with disabilities who are pregnant, violence can result in pre-mature birth or death of the fetus, thereby compounding the devastating effects of violence. This can also result in the woman's loss of her ability to conceive again because of the related trauma.

6. **Impact of violence in war, conflict and natural disasters**

   Violence against women with disabilities in situations of armed conflict, racial/ethnic and religious violence, and gender-biased cultural practices limit their access to food, shelter, health care, safe working environments, marriage and social integration. These effects can be observed in pre-conflict, conflict and post-conflict situations.

Additionally, in situations of conflict and natural disasters, women with disabilities often find themselves in refugee camps that are ill-equipped to meet their accessibility needs. As a result, adequate sanitation and nutrition may be impossible as toileting facilities, safe drinking water and food distribution canters may be located in inaccessible spots, resulting in poor nutrition and increased risks of disease.

Children and youth with disabilities are also affected by social norms and inequality, which increase their risk of being exposed to violence. Types of violence and vulnerability to GBV will be different for girls and boys of different ages and with different types of disabilities, as they are influenced by societal norms relating to age, gender and disability.

Children with disabilities, particularly girls with disabilities, may be denied the right to education, particularly in low-income settings where families may prioritize non-disabled children due to limited

resources. They may also enjoy less access to the formal and informal networks promoting protective skills and knowledge relating to GBV and healthy sexual relationships throughout different life stages.

As some children and youth with disabilities are dependent on others for daily care and activities, this may be used as a way of controlling or exercising power over the individual. It also hinders their ability to socialize, access services or move about freely in the community.[16]

[16] file:///C:/Users/gts/Downloads/GBV-Against-Children-and-Youth-with-Disabilities-Toolkit.pdf

Intellectual disability and SGBV[17]

Sexual abuse or exploitation of people with intellectual disability

Unfortunately, statistics show that people with disability experience all forms of abuse at much higher rates than people without disability. They share common symptoms including distorted thinking, emotion and impulse dysregulation, and interpersonal difficulties that make it difficult for them to understand they are being abused.

Reasons for this include:

- inadequate sexuality education on where and when it is acceptable to be touched by other people
- inability to resist, protest or stop abusive behavior from happening
- lack of awareness about the fact that a person has the right to decide what happens to their body, especially if they are used to other people constantly attending to their physical needs
- being raised in situations where they are used to being told what to do, which makes it natural for them to go along with the requests or demands made by an abuser
- agreeing to engage in sexual activities to fulfil unsatisfied cravings for attention, affection or rewards
- Consenting to the initial sexual activity, but not to the sexual activity that follows, which would amount to abuse.

Just as for the general
population, assaults against people with disability are more likely to be perpetrated by somebody they know, such as a family member, work colleague or someone they live with. Research also shows that sexual assaults on people with disability are less likely to be reported.

[17] https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/intellectual-disability-and-sexuality

CHAPTER 3: GUIDING PRINCIPLES

"According to the principles of humanitarian aid and the international legal framework related to GBV, the humanitarian community, host governments, donors, peacekeepers, the UN and all others engaged in working with and for affected populations are collectively accountable for preventing and responding to GBV.

1. Survivor-centered approach

All interventions aiming at preventing and responding to GBV should be guided by the Survivor Centered Approach, which requires all actors, case management and specialized services providers engaged in GBV programming to prioritize the rights, needs and wishes of survivors.

The survivor-centered approach is based on a set of principles designed to guide professionals—regardless of their role—in their engagement with persons who have experienced GBV. The survivor-centered approach aims to create a supportive and empowering environment in which a survivor's rights are respected and the person is treated with dignity and respect.
The approach helps promote the survivor's recovery and his/her ability to identify and express needs and wishes, as well as reinforce his/her capacity to make decisions about possible interventions[18].

Embracing a survivor-centered approach:

DO support all individuals who seek your help without any judgment or prior assumptions.

DO positively engage adolescent girls and boys. Generally, adolescent girls and boys aged 15 – 17 are mature enough to make their own decisions. Do ask if they want to involve a caregiver or a friend in the conversation, but do not force them to do so.

DO support boys and girls. Boys and girls should be supported to express their views safely, and these views should be considered with respect and taken seriously.

DO provide persons and women with disabilities with the opportunity to speak without the presence of their caregiver, if they wish so and this does not endanger or create tension in the relationship with the caregiver.

DO positively engage the caregiver of the child or the person with a disability, if such caregiver is present with him/her and/or if the child or the person with disability requests that you contact his/her caregiver.

[18] GBV SOP Lebanon

DO NOT assume that a man or boy who reports sexual violence is gay or bisexual. Gender-based violence is based on power, not on someone's sexuality. If a man or boy is raped, this does not mean he is gay or bisexual.

DO recognize that anyone can commit an act of gender-based violence, including spouses, intimate partners, family members, strangers, parents, or someone who is exchanging money or goods for a sexual act.

DO recognize that anyone can be a survivor of gender-based violence – this includes, but is not limited to, people who are married, elderly individuals or people who engage in sex work.

DO NOT assume your own values, beliefs and assumptions about childhood and the roles of the child and the family are correct and avoid imposing them on children. It is important to guarantee the appropriate ways of child participation and involve the children in the decision-making process.

Guideline for the service providers:

How to approach a person with disability in a safe space?

If, during your session / activity, you notice any of the signs that might indicate that a person with disabilities is exposed to any kind of violence, you should:

- Find the approach (speech, writing, gestures, pictures and posters, or other activities that may help to convey and understand information) that works best for the person with disability. You can ask the persons with disabilities or their caregivers for their preferred communication method and you should always be prepared to try an alternative approach if one method does not work. Persons with disabilities have many different skills and capacities, which you can use to communicate.
- If a person does not feel comfortable communicating with you on in his/her own, or you cannot find an appropriate method of communication, you can also talk to the caregiver.
- Provide the caregiver with a description about the survivor's indicators and ask general questions about them. Inform the caregiver that there is a person in the center (the case manager) who might help.
- Watch for signs that persons with communication difficulties are not comfortable (e.g., becoming distressed or agitated or start crying), particularly when you are talking with their caregiver.
- Also, pay attention to the indicators related to the caregiver him/herself (his / her response

and cooperation)

- If you feel that the survivor is uncomfortable, or the caregiver's response is not genuine, or he/she gives you unconvincing information, talk to the case manager, in the center and in the presence of the person with disabilities' and the caregiver, so he/she can contact them and start his/her assessment.
- Talk with your supervisor and the case manager and discuss the survivor's situation (Immediate Response Conference).
- The case manager needs to follow the SOPs when conducting the risk assessment. If that's an option, he/she can conduct it by means of a home visit to observe the relations between the family members.
- If the family refuses to provide information, the case manager needs to refer the case to the Family Protection Department, via the referral form, and to explain the situation by describing all the risk indicators observed.

2. Disability Safe Spaces

The work of all service providers in the Disability Safe Spaces shall be guided by the principles outlined in the *United Nations Convention on the Rights of Persons with Disabilities* and reflected in the *Disability Services Act 2011*:

- Respect for the person's inherent dignity and autonomy, including the freedom to make one's own choices, and self-independence.
- Non-discrimination.
- Full and effective participation and inclusion in society.
- Respect for difference and acceptance of persons with disability as part of human diversity and humanity.
- Equality of opportunity.
- Accessibility.
- Equality between men and women.
- Respect for the evolving capabilities of children with disability and respect for the right of children with disability to preserve their identities.

In addition, Disability Services shall be guided by the following principles:

- **Involvement of people with disability** – people with disability are meaningfully engaged in developing policies and programs and developing legislation.
- **Community engagement** – the effort of the whole community effort to support the inclusion of people with disability in the life of their communities.
- **Simplicity** – the service system for people with disability is easy to understand and navigate.
- **Choice** – people living with disability are the natural authorities over their own lives and can make choices about their care and support.
- **Inclusive approach** – products, services, environments and communities are accessible and usable by all people to the greatest extent possible, without the need for specialized modification.
- **Person Centered approach** – policies, programs and services for people with disability are designed to respond to the needs and wishes of each individual, are developed collaboratively by the service provider and the person with disabilities, and are centered on the individual needs.
- **Independent Living** – services and equipment enable people with disability to be independent.
- **Collaboration –** governments work together to ensure that policies and programs work well together.

3. Basic principles to work with GBV survivors

In a complementary way, in case of situations involving disability and GBV it is important to take into consideration and apply basic principles when working with GBV survivors:

- In all cases, ensuring the safety of the survivors and their families. In general, if there are indicators of gender-based violence against any members of the family (children, women), it is very likely that other children within the family will be subjected to violence by the abuser. Therefore, a general assessment of all family members must be carried out, either in the center or through the Family Protection Department, to ensure the family's safety. Safety is a priority in both the short and the long term, and guaranteeing the safety of survivors and their families includes devising a safety plan with the survivors, arranging transportation to a shelter or a safe house, or implement any other safety measures to protect the victims.
- Listening and building trust: this creates a supporting environment that allows the victims to recover (children or adults).
- Providing emotional support: this is achieved by showing care and compassion to the survivors (children or adults).
- Providing information: receiving all the necessary information helps survivors make informed decisions regarding the services provided.

- Respecting the wishes, rights, choices, and dignity of the survivors (children or adults) and ensuring that they are in control of the situation, which guarantees the empowerment of the survivors by restoring the power that was taken from them by the abuser.
    - Providing counsel to survivors regarding the institution from which they want to request help and respecting their wishes.
    - Conducting the interview in a private place.
    - Persons of the same sex as the survivor should conduct interview and tests, unless the survivor prefers otherwise.
    - Always showing respect, as well as providing a judgment-free treatment of the victim.
    - Only asking relevant questions.
    - Avoiding asking the survivor to repeat his/her story during different interviews.
- Informed consent: the adult, child, or guardian (when appropriate) shall give his/her consent before any information regarding him/her can be shared.
- Guaranteeing confidentiality: confidentiality of information must be guaranteed when working with victims and their families.

  - If the survivor gives informed and specific consent, then it is possible to share only the relevant information for the purpose of helping the survivor, such as to arrange the transfer to a different service provider.

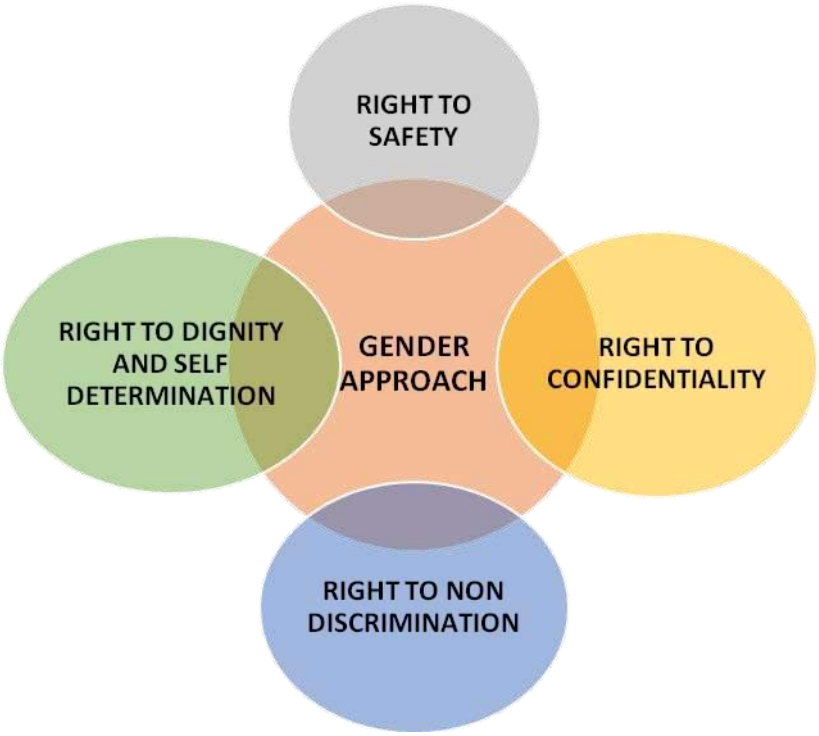
  - All recorded information from survivors must be preserved in secure files
- Ensuring that no discrimination takes place during the interactions with and the provision of services to survivors.
- Showing respect for the evolving capacities of children with disabilities and for their right to preserve their identities.
- Promoting the best interest[19]of the survivor. This principle is particularly important when dealing with survivors who may not have the capacity to consent to the services. If an adult lacks the capacity to consent to the interventions, the caseworkers and service providers have a duty to provide care in the best interest of the survivor. Such decisions should be made, however, in consultation with the service provider's supervisor. Decisions or actions considered to be in the best interest of a survivor are those that: • protect the survivor from potential or further emotional, psychological and/or physical harm; • reflect the survivor's wishes and needs;

  • examine and balance benefits and potential harmful consequences; and

  • promote healing and recovery.

[19] file:///C:/Users/gts/Downloads/GBV-Disability-Toolkit-English%20(3).pdf

What are the key guiding principles to ensure we do no harm GBV survivors?



Guidance note for non-specialized centers and safe and ethical referral[20]

4. Protocol of action for case managers

If approached by a survivor seeking help, you should:

• Be aware of the referral pathways and services available in their area.

• Comfort the survivor making healing statement such as: "It's not your fault", "I believe you", "I am very glad you told me", "I am sorry this happened to you", but avoiding a victimization tone: "You are very brave for telling me".

• Explain that agencies providing case management have specialized personnel that can support the survivor in the best way and will work with her/him to find solutions to her/his needs.

[20] GBV SOP Lebanon

• Explain the services available: if requested, provide the survivor with information on case management service providers, briefly explaining that these service providers have specialized staff who will assist the survivors in accessing the different types of assistance they need, including psycho-social assistance, medical assistance, legal assistance, and assistance to find safe shelter if needed. All these services are free of charge. Explain that specialized medical assistance is available and can be provided after the incident, regardless of how much time has elapsed since the incident. Service providers assist all refugees without any discrimination, the information is confidential, and nothing is done without the express consent of the survivor.
• Should your organization's policy require you to refer to your line manager/supervisor before taking any actions, this must be explained to the survivor.
• Ask and receive the survivor's consent prior to put her/him in touch with a primary focal point, using the GBV Referral pathway and facilitating the contact between the service provider and the survivor (i.e. arranging the date and time of appointment and the means of transportation).
• Ask the survivor which his/her preferred option is and whether she /he would prefer to be contacted by a specialized service provider.
• Only proceed to the referral when the survivor has given his/her consent.

If approached by a survivor who seeks help, you should not:

• Advise/encourage the survivor to access a specific type of service. Limit your interaction to providing information and avoid advising the survivor according to your preferred option.
• Ask questions about the incident to the survivor. Remember that it is not your role to decide whether the person is saying the truth or not, or whether they really need help or not. Asking the survivor to repeat his/her story several times will traumatize him/her unnecessarily, as you are not the one who is going to provide the service. • Interrupt him/her when he/she starts talking about what happened to him/her.
• Raise expectations – be honest and accurate (e.g. do not say things like "they will give you money, they will solve all your problems").

REMEMBER: Difference between Advising and Informing

Giving Advice means: telling someone what you think they should do and how you think they should do it (i.e. giving your opinion)
Giving advice is not useful because – among other reasons – you might give the "wrong" advice, which can have negative consequences for the survivor. This can lead to a worsening of the survivor's problems.
Counselling is about the beneficiary's opinions and judgments, not the counselor's. On the contrary, giving advice is based on your values and beliefs.

Providing assistance to a survivor is about empowering survivors to make their own decisions about their own lives. It is up to the survivor to decide the best way to solve her/his problems.

Giving Information means: providing someone with the necessary facts and information so he/she can make an informed decision about the best course of action.

Giving Information is useful because it empowers a survivor to have control over her/his choices. The survivor, not the service provider, has the responsibility to make the right decisions about her/his life.

4.1. Guidance to the Case Manager in Responding to Survivors (Children / Adults)

LOOK

DO address basic urgent needs first, if any. Some survivors may need immediate medical care or clothing. DO ask the survivor if he/she feels comfortable and safe talking to you where you are. If a survivor is accompanied by someone, do not assume it is safe to talk about the survivor's experience in front of that person. DO provide practical support like offering water, a private place to sit, a tissue etc. DO ask the survivor to choose someone he/she feels comfortable with to translate for them if needed.	DO NOT ignore anyone who approaches you and shares that they have experienced something bad, that made the, uncomfortable, something wrong and/or violence. DO NOT force help on people by being intrusive or pushy. DO NOT overreact. Stay calm. DO NOT pressure the survivor into sharing more information beyond what they feel comfortable sharing. The details of what happened and by whom are not important or relevant to your role, which rather involves listening and providing information on the services available.

What to say/do…

- Allow the survivor to approach you.
- Listen to their needs.

- “You seem to be in a lot of pain right now, would you like to go to the health clinic? We can continue talking afterwards.”
- “Does this place feel safe for you? Is there another place where you would feel safer? Do you feel comfortable having a conversation here?”
- “Would you like a glass of water? Please feel free to have a seat.”

LISTEN

DO treat any information shared with confidentiality. If you need to seek advice and guidance on how to best support a survivor, ask for the survivor’s permission to talk to a specialist or colleague. DO manage any expectations on the limits of your confidentiality, if applicable in your context. DO manage expectations on your role. DO listen more than you speak. DO say some statements of comfort and support, especially stressing that what happened to them was not their fault.	DO NOT write anything down, take photos of the survivor, record the conversation on your phone or other devices, or inform others including the media. DO NOT ask questions about what happened. Instead, listen and ask what you can do to help. DO NOT make comparisons between the person’s experience and something that happened to another person. Do not communicate that the situation is “not a big deal” or unimportant. What matters is how they feel about their experience. DO NOT doubt or contradict what someone tells you. Remember that your role is to listen and provide information on the services available.

What to say/do…

- “How can I help you?”
- Everything we talk about will stay between us. I will not share anything with anybody without your permission.”
- “I will try to support you as much as I can, but I am not a counselor. My role is to provide you with information on the services I know are available for you.”

- “Please share with me whatever you want to share. There is no pressure to say anything you do not want to or do not feel comfortable saying.”
- “I’m sorry this happened to you.”
- “What happened was not your fault.”

GUIDE

DO respect the right of the survivors, if adult, to make their own decisions. DO share information on all services that may be available, even if they are not GBV specialized services. DO tell the survivor that they do not have to make any decisions now, they can change their mind and access these services in the future. DO ask if there is someone, a friend, family member, caregiver or anyone else, who they trust and to whom they could turn for support. DO offer your phone or communication device, if you feel safe doing so, to the survivor to contact someone they trust. DO ask for permission from the survivor before taking any action. DO end the conversation supportively and limit the number of people informed about the incident.	DO NOT exaggerate your skills, make false promises or provide false information. DO NOT offer your own advice or opinion on the best course of action or what to do next. DO NOT assume you know what someone wants or needs. Some actions may put someone at further risk of stigma, retaliation, or harm. DO NOT make assumptions about someone or their experiences, and do not discriminate for any reasons, including age, marital status, disability, religion, ethnicity, class, sexual orientation, gender identity, identity of the perpetrator(s) etc. DO NOT try to, reconcile or resolve the situation between someone who experienced GBV and anyone else (such as the perpetrator, or any third person such as a family member, community committee member, community leader etc.) DO NOT enquire about or contact the survivor after you end the conversation.

What to say/do…

- “Thank you for sharing your experiences with me. Our conversation will stay between us.”
- “I am not a counselor and I cannot give you any advice. However, I can provide you with the information that I have. There are some people/organizations that may be able to provide some support to you and/or your family. Would you like to know more about them?”

- “Here are the details of the service, including the location, the opening hours, the cost (if applicable) and the name of the person to whom you can talk.”
- “Is there anyone who you trust and to whom you could turn for support, maybe a family member or a friend? Would you like to use my phone to call anyone you need at this moment?”
- “When it comes to the next steps, the most important thing to consider is what you want and what makes you feel comfortable.”
- “Do not feel any pressure to make any decisions now. You can think about things and always change your mind in the future.”
- “I cannot talk to anyone on your behalf to try to resolve the situation. But what I can do is to support you during our conversation and listen to your concerns.”
- “It sounds like you have a plan about how to proceed from here. This is a positive step.”

5. Some specific guiding principles for working with children with disabilities:

As children rarely seek help on their own, it is rare for service providers to encounter cases where a child discloses gender-based abuses. However, it could happen to anyone who interacts with children, especially if they do so on a regular basis working in the community (teachers, health workers such as nurses, community health workers, hygiene promoters or other community outreach workers who are regularly in contact with community members).

More often, you might hear rumors about cases of child abuse or be approached by adults who seek support for children who are being abused.

In this situation, provide all the necessary information, i.e. provide the service to the adult seeking your support but DO NOT investigate the case or try to interview the child.

Children encounter extra barriers when seeking support: for instance, children may not understand what is happening to them, while they may experience fear, embarrassment, shame about the abuse, or fear of losing their caregiver(s). These barriers are more significant when it comes to children with disabilities.

Hence, it is extremely important that you provide a positive and supportive response to children, to increase their sense of safety and psychological well-being.

Your role is not to conduct a detailed interview about what the child has experienced or makes a care plan for the child. Your role simply involves listening to the child if she/he wants to talk to you and provide all the information that is relevant for the child.

5.1. What to take into account?

In this process you must consider;

- Children with disabilities must enjoy all human rights and freedoms, on an equal footing with other children.
- The best interest of the child shall be prioritized in all procedures related to children with disabilities.
- Children with disabilities must have the right to freely express their points of view regarding matters that concern them, and those points of view shall be taken seriously, based on the age and maturity of the child, on equal terms with any other children. They must receive help adequate to their age and degree of disability, which enables them to realize that they have the right to it.

How to guarantee a good response by the case manager when dealing with children?

LISTEN and WATCH:

- Ask the child whether she/he wants anyone to be with her/him while she/he talks with you. If she/he wants, make arrangements to have the person join you (offer a phone to the child to make a call).

-Be calm and patient – allow the child to be heard.

- Do not display shock or disbelief. Pay attention to your non-verbal communication.

- Accept what is being said without judgment.

- Let the child use her/his own words. Use open-ended questions and avoid multiple-choice or yes/no questions, which can be confusing and lead the child to give inaccurate responses.

- Pay attention to the child's non-verbal communication (drawing, playing).

- When "listening" to children with communication difficulties, it is critical to consider body language, gestures and facial expressions.

REASSURE:

-Reassure the child that him/her telling you what happened is perfectly fine.

-Use healing statements such as "I believe you" and "it's not your fault", both at the beginning and throughout the conversation.

Healing Statements

- "I believe you" – builds trust

- "I am glad that you told me" – builds a relationship with the child

- "I am sorry this happened to you" – expresses empathy but without victimizing her/him

- “This is not your fault” – non-blaming

- “You are very brave to talk with me” – reassures and empowers

- “You are safe here “– calms the child and gives him safe space.

EMPOWER:

- Respect the child’s opinion, beliefs and thoughts.

- Inform the child that she/he can stop speaking with you at any point.

- Acknowledge the child’s bravery and strength.

- Avoid making promises you can’t keep—manage the child’s expectations. Do not use sentences like “everything will be ok”.

- Explain the child that you might need to share with someone some of the information she/he provides, in order for the child to feel safe.

- Stay with the child until she/he calms down. Never leave the child unattended when she/he is still in distress.

- If a trusted adult was not present during the talk, ask the child if she/he has someone that she/he trusts. Bring the person to the child or accompany the child to the person if the child asks you to do so. Make sure that the child stays with an adult that she/he trusts after your conversation.

GUIDE:

-If a child protection (CP) actor is present in the area, refer the child to the child protection actor, subject to the prior consent of the child and the caregiver. If there are not CP actors available in the area but there are in other parts of the country (e.g. the capital) and the child and the caregiver want you to refer the case, please refer them to the CP/GBV actors. Please discuss how to refer children survivors of GBV with CP and GBV actors during the preparation phase.

- If the child wants to access services present in the area (e.g. health services), refer the child, subject to the prior consent of the caregiver.

- Where there is no child protection actor or other services needed by the child, ensure that the child is with an adult that she/he trusts after the session and provide the adult with information on the services available.

Children with special physical and intellectual needs should have access to the same facilities as other children. Disability Safe spaces *have an obligation to ensure such access,*

so that children with disabilities can participate in the services provided by the centers *without being hindered by their special needs*. Annex 4 Minimum Standards for Child Safe Spaces

5.2. Parenting discipline for Children with Disabilities

Discipline involves helping your child learn how to behave, as well as how not to behave. It works best when you have a warm and loving relationship with your child.

Discipline and discipline strategies are positive. They are built on talking and listening. They guide all children towards:

- knowing what behavior is appropriate – whether it is at home, a friend's house, child care, preschool or school
- managing their own behavior and developing important skills like the ability to get along with others, both as children and as they get older
- Learning to understand, manage and express their feelings.[21]

What experts call "behavior management" is not about punishing or demoralizing your child. Instead, it is a way to set boundaries and communicate expectations in a nurturing, loving way.
Discipline — correcting children with disabilities, showing them what is right and wrong, what is acceptable and what is not — is one of the most important ways for parents to show their kids that they love and care about them. (Annex 5 Parenting discipline for children with disabilities.)

[21] http://raisingchildren.net.au/articles/autism_discipline_strategies.html/context/1391

CHAPTER 4: GBV CASE MANAGEMENT IN PWD CARE CENTERS

Case management is a collative, multidisciplinary process promoting quality and effective outcomes through communication and the provision of appropriate resources to meet an individual's needs. These process includes assessment, planning, implementation, coordination, monitoring and evaluation of different options and services.

All service providers are considered part of the case management team for the survivors. Each service provider assesses the specific needs of the GBV cases, builds a specialized intervention plan, undertakes the required intervention as a service provider, participates in the case identification process, provides the case manager with periodic progress reports, and participates in case conferences.

The goal of case management is to empower the survivor/child and, where appropriate, her/his caregiver, by increasing her/his awareness of the options available to deal with the problem and assisting her/him to make informed decisions about what to do. Case management ensures that the survivor/child is involved in all aspects of the service planning and delivery. A case management approach is useful when dealing with persons with complex and multiple needs who seek access to services from a range of service providers, organizations, and groups.

Case managers must have the skills to manage cases in line with the principles mentioned above in Chapter 3, a deep understanding of their roles and responsibilities, and the ability to handle difficult situations professionally and with cultural sensitivity.

The role of the case manager:

- Support the best interest of the survivor.
- Assess the survivor's needs.
- Support care and treatment goals and plan interventions to meet the needs.
- Provide, coordinate and follow up on the provision of services.
- Provide options, as opposed to of making decisions on behalf of the survivor or giving advice.
- Adhere to the basic principles of working with protection cases.
- Follow the informed consent procedures, in accordance with the local laws, as well as the age and developmental stage of the child.
- Secretly apply the protocols to reflect confidentiality limits.

- Assess the survivor's current health status, safety, psychosocial and legal / justice needs.

- Identify the survivor's strengths and involve her/him in the process of care and treatment based on her/his strengths.

- Work independently and collaborate with other service providers.

- Document the case.

Important note:

It was agreed, in accordance with Jordanian National Framework for Family Protection, to change the title "Case Manager" to "Case Coordinator"

Role of service providers / personnel who are not case managers:

The role of service providers is limited to identifying GBV cases, in consultation with the case manager, and transferring them to the case manager or coordinator.

However, if a case manager is not available at the center, the case may be transferred to external service providers.

Important Note: In centers where there is only one case manager and there is no possibility of assigning a second case manager, it is advisable that another service provider or coordinator is trained to manage GBV cases, in order to replace the case manager if this latter is not available

Service providers shall:

- Identify the type of violence / abuse to which survivors / children can be subjected (case identification).

- If it is not established that the person is suffering from violence, but there are doubts about it, internally refer the case to the case manager and encourage the survivor to seek help from the case manager.

- Be informed about the case managers dealing with gender-based violence and child protection in their geographical areas.

- Avoid asking probing questions and conducting in-depth interviews with survivors / children.

- Participate in the case conference led by the case manager, to discuss with the case management team the progress made by the survivor, so that all service providers have the opportunity to provide updates on the performance/progress of the survivors in their services.

- If no case manager is available, use the gender-based referral model for gender-based violence and the inter-agency referral model for child protection cases.

If no case manager is available, provide services for the survivor if necessary.

Steps of GBV case management in the Disability Safe Spaces

It is important to be aware of what the service provider can and cannot do. Although the services are managed by case managers, it is important to know that GBV response requires specific care and awareness.
Not all case managers can provide GBV care services: it is therefore important to identify the adequate staff to guarantee quality GBV services.

STEP 1: You can

Case identification and disclosure: The case identification and disclosure can be made through the initial contact with the victim when there are protection concerns. This can also be done by the survivors themselves when disclosing the case to the case manager or through awareness-raising activities (e.g. awareness-raising lectures on protection). This step is the opportunity for the case manager to build trust with the survivor: once a relationship of trust is built, the case manager takes the survivor's informed consent in order to provide case management and complete the assessment or make a referral to a specialized service.

Through the initial contact with the beneficiary, you can identify some signs and symptoms of violence. Some of these indicators can be recognized at the first contact, while others will require some sessions. The following is a non-exhaustive list of GBV indicators:

- **Signs or indicators of GBV in adults**

Psychic/Emotional and Behavioral indicators:

- Fear of the perpetrator, which can range from terror to a general feeling of discomfort or anxiety.
- Appearance of psychological symptoms associated with fear and phobia, such as a feeling of insecurity when leaving home.
- Overreaction to things or events that are not supposed to cause anxiety, such making a phone call from home, or a delay in returning home.
- Postpone decision making to avoid asking the partner, including simple decisions such as spending a small amount of money, buying a commodity that the child needs, scheduling a doctor appointment or inviting a friend to visit.
- Having a history of drug abuse may be an indicator of exposure to violence. Drugs can be used as a means of self-healing or contact with the perpetrator.

- High levels of stress, without a clear explanation of its cause.
- Mind-wandering and neglecting to take care of personal appearance.
- Suicidal tendencies, due to the feeling that there is no way to get rid of the perpetrator except by murder or suicide and to depression feelings.
- Repeated separation and reconciliation with the perpetrator.
- Further behavioral conducts indicating exposure to violence: dispassion, bursts of tears, difficulty to cope that gets worse every day, defensive or aggressive attitudes, reluctance to speak when the perpetrator is present, tendency to minimize the importance of what is happening.

- Sleeping and eating problems. These can be accompanied by psychophysiological symptoms such as gastrointestinal problems and menstrual disturbances.
- Lack of confidence and trust.
- Behavioral changes.
- Objection to undress and bath.
- Disaffection with the school or the center.
- Regressive behavior.
- Tendency to secrecy.
- Self-harm or attempted suicide.
- Social interaction difficulties.
- Obsessive thoughts about the aggression.
- Attention and focusing problems.
- Anxiety and depression symptoms.
- Substance abuse.
- Regarding interpersonal, caring or sexual relationships: rejection of physical contact; seductive behavior (particularly girls); precocious sexual behavior or knowledge, unexpected for the age.
- Excessive interest in adults' sexual behavior.
- Confusion in sexual orientation.
- Sexual adjustment problems, dependency, aggressiveness.

- **Physical indicators**

- Clear injuries or incidents that are difficult to explain.
- Marks of bruising and accidental burns such as cigarette burns.
- Frequent fractures and bruises.

❖ **Also, there are signs associated with the perpetrator**

- Extreme jealousy or irrational desire to control the other person.
- Attempt to control the time spent with the service provider.
- Tendency to talk on behalf of the other person.
- Insistence on staying close to the person and accompanying him/her.

- Try hardly to show interest.

❖ Signs or indicators of physical abuse/violence towards people with disabilities

It is very difficult to detect abuse/violence inflicted on people with disabilities, due to the physical and psychological behaviors related to the nature of their disability. It is therefore essential to observe changes in health or behavior (especially changes that are not related to their disability) as possible indicators of violence.

Indicators or warning signs of abuse include evidence of any unusual activity taking place in a person's life. Although some indicators are clear signs of mistreatment, in some cases, mistreatment may not have taken place at all. This makes it all the more important to take into consideration the specific person and any health or behavioral problems from which she/he may suffer. Some people are more prone to injury than others: for example, some medications or health issues like hemophilia (which causes slow blood clotting) can easily cause bruising. In addition, some people exhibit self-harming behaviors that cause injuries similar to those provoked by abuse. As a consequence, even if health or behavioral problems are detected, it remains essential to evaluate all possibilities, in order to ascertain whether violence is the actual cause.

- When interacting with a person with disabilities, it is important to pay close attention to any changes in the person's appearance or behavior. Sudden or gradual changes in appearance or behavior may be a sign of abuse or negligence.

❖ In most cases, signs of abuse for children with disabilities are similar to those detected in children in general, such as:

- Signs that appear as a result of mouth gagging.
- Signs of beating, including those left by fingers, hands, belts, or sticks.
- Missing teeth.
- Spots of baldness (as an of hair pulling)
- Urinary incontinence persisting after the kid has been trained to control the bladder, as well as sudden regression to childish behaviors, such as thumb-sucking.
- Sudden changes in the child's attachment to others (abnormally or inappropriately).
- Sudden mood swings.

❖ Indicators that abuse or violence is being perpetrated by caregivers towards people with disabilities:

- Refusal to follow directives or complete essential tasks.
- Exhibition of aggressive/controlling behavior.
- Use of verbal or physical threats as a way of inspiring fear.
- Humiliation and name calling of people with disabilities.

- Display of unwelcoming or uncooperative behavior during house visits.

NEXT STEPS:

If the centers are not specialized in GBV, we recommend not to carry out the process. The best option is to be aware of the referral pathways and establish partnerships with GBV-specialized organizations.

- **Case assessment**: Gathering information to make decisions about the appropriate response to the case. The aim of the initial assessment and collection of information is to evaluate the status of the case and to identify immediate and long-term needs.
- **Case planning**: It includes the development of a safety/action plan in collaboration with the victim (in the case of children, the plan is developed with the main caregiver). Work plans are elaborated according to the identified needs and based on the victim's wishes.
- **Implementation**: At this stage, there is a need for coordination and cooperation with other organizations, to ensure the referral to other services and the provision of services (based on a model established in the Standard Operating Procedures Manual). Case managers prioritize the cases based on the following classification:

  Emergency cases - The referral is immediate to ensure response within 24-48 hours. This includes cases in which the victim or anyone else is at risk.

  Medium-priority cases - The referral is completed within a week. This includes cases where there is a risk to the health or welfare of the victim if the service is not provided.

  Normal cases - The referral is within 2-4 weeks. This includes cases where there is a regular need for services.
- **Follow-up on the case**: The follow-up should be continuous, to ensure the effectiveness of the response, where the degree of follow-up depends on the nature of the case, its needs, and the degree of risk.

  As a follow-up, a Follow-up case conference is held periodically at the invitation of the case manager and with the participation of the case management teams from different service providers. The services provided to the GBV survivor and his/her family are monitored, evaluated and documented and further interventions are planned. The follow-up case conference involves:

  1. Reviewing the procedures agreed within the plan to protect and support the survivor and his / her family.

  2. Sharing experiences, including good practices, constraints, and, if necessary, the reasons why the services have not satisfied the required standards.

  3. Reviewing the plan of intervention developed and agreed upon during the case conference and meet its objectives.

4. Discussing whether the abuser(s) need rehabilitation services, assessing the family support needs, and taking any actions that would enable them to integrate after the violence has ended.

- **Case closure**: This represents the last step of the case management and includes closing the case after reviewing it and ensuring that the victim's needs have been successfully met. The case file is often closed when:

  - The planned objectives have been achieved.
  - The victim is safe and receives sufficient support and care.
  - The victim is deceased.
  - The adult victim no longer wants support / services. In the case of children, when the caregiver no longer wants to receive support / services and there is no basis for refusing to respect their wish (the child is safe)..

Work protocol between partners in the context of the case management methodology:

The organization managing the case must adhere to the following protocol:

1. The coordination function is assigned to the case manager and all parties concerned are invited to participate in the case conferences;

2. The participation of the institution in charge of the identification and detection of cases of violence and child protection, which reported on the case in the case management team through the follow-up of the case, the provision of service, and the participation in the meetings of the status conference and decision-making;

7. All institutions represented in the case management team (case conference) shall send the technically qualified person, who has the authority to make decisions on the interventions for survivors;

4. The service provider should assess the risk factors of the survivor and his / her family by assessing the degree of physical and psychological risk, and work on an immediate response with the participation of all relevant partners;

5. The case manager shall periodically inform the case management team about the developments and updates related to the survivor and his family;

6. The case manager must collect and secure the necessary information, follow up on all procedures and services needed by the survivor and his / her family and on the measures adopted by the service providers in response to the situation, and ensure that the case management team does not delay the compilation and exchange of information;

7. The service provider shall involve the survivor or her/his representative at all stages, and through his knowledge, and listen to his opinion concerning the options available, the consequences of each of them, and the preferred course of action;

8. A participatory decision-making approach should be adopted within the case management team;

9. The decision to close the file shall be taken by the partners based on the risk factors assessment. The final decision should be made by means of a vote by the members of the case management team and according to the majority opinion;

10. The party acting as a case manager shall commit to build partnerships and sign memorandums of understanding with the institutions providing specialized services.

Case management paths

Two approaches have been adopted to manage the cases among the institutions concerned with dealing with cases of GBV, domestic violence and child protection, based on the reporting requirements set by the law, as well as the provisions and specific instructions regulating the role of and the procedures adopted by the institutions when dealing with such cases. In particular, it falls under the responsibility of the case manager to establish partnerships and sign memorandums of understanding with all the institutions concerned with the provision of services (medical, psychological, social, legal, educational, etc.) in a manner that ensures the efficient organization of inter-relations between them with the aim to provide services to the users.

1. **The path of case management** between the partners in cases that do legally require notification to the relevant party, which, depending on the nature of the case and the group at risk, as well as on whether the act is a felony or misdemeanor according to the applicable national legislation, has to participate in the case management team. This organization manages and follows up on the case by i) calling for all meetings related to the survivor and his / her family; ii) following up on the decisions made during such meetings; iii) ensuring the coordination of the procedures and services to be provided by all partner institutions to the survivor; and iv) taking into account the conditions of the survivor, his / her wishes and those of his / her family.

2. **The path of case management** between the partners in cases that do not legally require notification to the concerned party (and whether the act committed does not amount to the level of felonies and misdemeanors in accordance with the national legislations, laws and regulations) In this situation, the institution that received or discovered the case is responsible for all stages of the case management process: evaluation, coordination, planning, referral and follow-up until the closure of the case file.

All the centers must have a Mapping and case paths:

Mapping can be useful in many aspects:

- It assists agencies / task forces in identifying key providers to whom the survivors can be referred;

- Mapping should include the identification of the following services, which may be useful in addressing gender-based violence and child protection cases:

- Case management;
- Actors concerned with safety and security;
- Psychosocial support;
- Legal services;
- Health / medical services, etc.

- Mapping should include the identification of other services that the victim might need, other than the above-mentioned ones, such as cash assistance, provision of non-food items, etc.

Strategies for prevention of gender-based violence and violence against children

Although prevention and response are separate areas of intervention, they are however interrelated, as many elements of the response to gender-based violence and violence against children are also preventive measures.
In developing prevention strategies, it is essential to address not only the affected individuals (both adults and children), but also the wider community, as this latter can be influential in creating a culture of non-acceptance of gender-based violence and violence against children and people with disabilities.
Prevention is a long-term process and requires effective control so that strategies can be changed over time, if necessary, to maximize effectiveness. Developing prevention strategies is the same as developing

any other project or program: it requires good evaluation, good planning, good control, and significant human, financial, and technical resources.

Prevention is about providing persons with disabilities with tools that will allow them to take care of their own development and reinforce their identity by enabling them to build independent lives and build or strengthen their networks.

When dealing with people with disabilities, gender-based violence prevention programs and strategies shall adopt a human rights-based model that focuses on:

"**Participation"**: to enable people with disabilities to fully participate in social, political and economic life and in all the decision-making processes that affect their lives.

"Social inclusion": based on the values of equality of rights and opportunities and non-discrimination.

PREVENTION = Understanding the causes and contributing factors of violence and developing strategies to reduce or eliminate them.

Comprehensive guidelines for prevention:

- **Provide or participate in trainings** on gender-based violence, child protection, rights of persons with disabilities, social inclusion of PWDs and minimum standards for child protection in humanitarian contexts.
- **Adopt codes of conduct** for all task forces that focus on prevention of sexual exploitation and abuse.
- **Actively promote equal participation** of girls, boys, women, men and PWDs in the planning and delivery of services and the design of facilities and meet regularly with them to monitor the degree of availability, safety and security of services and facilities.
- **Ensure that services are inclusive and accessible.**
- Ensure that persons with disabilities, especially women, girls and the elderly, benefit from social protection programs.
- **Continue to raise awareness about gender-based violence, risks and issues related to child protection and people with disability,** and share that knowledge with security actors, the sub-working group on child protection and gender-based violence, and the disability task force.
- **Regularly participate in discussions with organizations working on child protection and gender-based violence** and with people with disability to strengthen prevention strategies.
- **Actively promote respect for human rights,** women's rights, children's rights, and support the role of women and youth as decision-makers on an equal footing.
- Implement awareness / life skills activities for children and parents / child care providers.

- Mobilize religious figures to talk about the protection of women, men, and children.
- Implement awareness raising activities promoting a more inclusive and accessible education system for children with disability.
- Look for people with disabilities, be them children, women and men, and engage them in the activities.
- As every act of sexual and gender-based violence involves both perpetrators of violence and survivors, prevention strategies must target both parties.

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- How to support survivors of gender-based violence when a GBV actor is not available in your area. (User and pocket guide)
- Minimum standards for child protection in Humanitarian action. (Global Protection Cluster)
- WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies (WHO 2007)
- Jordanian Law on the Rights of PWD 2017

Annexes:

Annex 1: Case Management Tools

The use of these tools requires prior training

1. Referral Form
2. Initial Interview Form
3. Consent to receive service Form
4. Children Risk Assessment
5. Violence detection and risk level identification Form
6. Case Management Plan
7. Communication and Guiding Principles Checklist (self-evaluation tool/Case Managers)

Annex 2: Home Visit Policy

Annex 3: Creative Interview Techniques

Annex 4: Disability Safe Spaces

Annex 5: Parenting discipline for children with disability

Annex 6: Tips for quality attention

Annex 7: Evaluation Tool(Tool for testing the staff attitudes to GBV before recruitment) .

Important note:

These specialized techniques cannot be used without prior training

Annex 1: Case Managements Tools

Referral Form This tool is used by the Case Manager Used when referring a case to external services	
Name of the association:	Referral date:
Gentlemen Ministry / Foundation:	Department:
Referral Date:	
Personal data	
Case Name:	Case No:
Gender: M/F	Nationality:
Date of Birth:	Address (Detailed): Phone No:
Nature of the problem (summary):	
Emergency ☐	Ordinary priority ☐
Nature of service required:	
Notification by phone: Yes No	
Name of the person who was notified:	

Initial Interview Form

This tool is used by the Case Manager during the first interview

Case Manager Name:		**Interview Date:**	
Persons attending the interview:			
Name:	**Gender:**	**Age:**	**Phone No:**
Relationship to the problem owner:		**Address:**	
Name:	**Gender:**	**Age:**	**Phone No:**
Relationship to the problem owner:		**Address:**	

Summary of the nature of the problem / reason for requesting the service from the person's point of view:

1.

2.

How did you know about the center?

3. **Outreach** **Referral** **Relatives** **Friends** **Others**

If the problem is related to a child:			
Child Name:	Child Age:	Child gender:	Child Nationality:
Disabled child? Yes No	Type of disability:		
Is he/she attending school: Yes No	School address:		
School grade:			

If the problem is related to a woman:		
Woman Name:	Age:	Nationality:
Marital status:	Education:	Profession: Is the person an employee?
Work Address:		

People living in the house:							
	Name	Gender	Relationship to the problem owner	Age	Education	Job	Does he/she have disability? If yes, what type?
1							

2							
3							
4							
5							
6							
7							
8							
9							
10							

Problem history:

Problem details (When it was first observed, repetition, intensity ...):

Any events or stress factors (death, unemployment, etc.) associated with the problem:

Previous attempts to address the problem:

Previous interventions:

Institution Name: Address: Phone No:

Nature of Intervention:

Result:

Intervention Date: From \ \ To \ \

Are there any reports? Yes No

Diagnosis: Forensic medicine

Specialist Physician / Hospital Other…….

The family has a copy of the report: Yes No

Annex Copy of the report: Yes No

Other Significant Information:

Nature of the required service / expectations from the service:
Results: Referral to Internal services /Mention …….. Referral to External Institution/Mention ……..

Consent to receive service form

This form is used by the Case Manager when external or internal referral to the service provider is needed.

I, (name) ..... give permission to (name of association) to share the information about the incident that I have reported with the provider(s) I have been referred to.

Understanding that the purpose of sharing the information with the provider(s) is to get the best protection and assistance possible, that the information you share will be treated with strict confidentiality and respect, and that any information will be shared only when necessary to provide the required service;
Knowing that this document means that any of the service providers listed below might contact me;

********* I agree that the information may be authorized by:**

- **Family Protection department**
- **Family member (Specify)**
- **UNHCR**
- **Ministry of Social Development**
- **Legal Adviser (Specify)**
- **Economic Empowerment**
- **Other Services (Specify)**

  …….
- **Please indicate what information should be obscured**

  …….

  ……..

  …….

Reasons for withholding information:

***The person prefers to personally communicate the information*The person is afraid of being hurt or otherwise harmed**

***Other (specify)**

Signature of beneficiary……

Signature of Case Manager……

Date……

This sample reads on the client in her/his native language.

The beneficiary must sign the form. However, if the person is under the age of 15 years, his/her caregiver is required to sign on his/her behalf.

Information about the beneficiary can only be shared with the service providers once the person has signed the consent form,
And it explains that the beneficiary can choose one of the services listed above.

This form shall be kept in the case manager's file.

Children Risk Assessment Form

4. **This form is used by the case manager when there are signs of violence or when the survivor has declared to be victim of violence**

Child Interview

1. General Information

Case Manager Name:	Date:
Child Name:	Nationality:
Father Name:	Birth Date:
Mother Name:	
Address:	Phone No:
School Name:	Grade:

Persons living with the child:

……..

Child's relationship with the adults in the family (relationship with parents, child-supportive relationships):

……

Presence of the primary sponsor of the child ande nature of the child's relationship with him / her:

……..

Child's relationship with other children in the family (siblings):

……..

Child's relationship with peers (school, neighborhood):

……

2. Information about the abuse

Persons exposed to abuse within the family:

……
……

Physical abuse:

……
……

Child's body area interested by the abuse:

……
……

Tools used:

……
……

When the abuse occurred:

……
……..**Repetition of the abuse:**

……
……..

Any previous injuries:

……
……..

Has the child visited the doctor after being abused?

……
……

Are there any medical reports?

……
……..

Neglect:

Child's commitment to school……

Child / Child Health Follow-up……

Response to illness……

Food habits……..

Hygiene habits……

Emotional abuse:

Child-directed verbal abuse……

Threats……

Blocking emotions or interacting with the child……

Sexual Abuse:

Sleeping arrangements……

Response of the family members during and after the abuse (parents, siblings, extended family)

……
……

Actions taken by the child before, during and after the abuse (child protection skills):

……
……..

Does the child want to return to the family house? Yes No Unspecified

What may change in a child's family environment for it to become safer?

……
…….

Is there another place or person the child would prefer to live with?

……
……

Does the child have concerns about anyone else in the family (whether this person is a child or an adult)?

……
……..

Open question:

Are there any other things happening in the family that you would like to talk about or share?
……..

1. Case Manager Notes:
Child Psycho-social Status: ……

……

Physical health status: ……

……

Child's interaction with the specialist during the session:

……

Other notes: ……

Violence detection and risk level identification Form

This form is used by the case manager when there are indications of violence or when the survivor has declared to have been victim of violence. Itis used before the risk assessment in case of children, but as the main tool for women.

Name of the person (child, woman): ……

Age: ……

Case Manager Name: ……

Relationship to the case……

Type of abuse: ……

Tool used for abuse: ……

Number	Indicators	Yes	No
1	The severity and frequency of abuses increased		
2	Someone has been trying to kill the survivor		
3	The survivor previously went to the hospital as a result of the abuse		
4	The survivor was seriously injured by the violence but did not go to the hospital		
5	The survivor refused to have the offender join/stay with her/him in the hospital		
6	The physical, psychological or mental health status of the survivor does not allow her/him to defending herself/himself if returning home.		
7	There is no safe place where the survivor can go		
8	The survivor fears returning home with the abuser		
9	There is no one in the survivor's environment who can provide him/her protection and security after leaving the hospital		
10	The survivor shows suicidal tendencies		
11	The survivor has developed an addiction to alcohol and/or drugs		
12	The perpetrator is addicted to alcohol and/or drugs		
13	The abuser enjoys and easy access to the survivor		
14	The survivor has already been assaulted using weapons or sharp objects		
15	The perpetrator has a criminal record		

Interpretation of results

Grade	Significance	Proposed action
1-5	Requires follow-up	Discussion of safety plans with the survivor, activation of the family support, reveal to the family protection department (once the survivor – whether child or adult – has given her/his consent). If the case does not require immediate protection measures: elaboration of an executive work plan, and periodic follow-up by the administration
6-10	Moderate (urgent)	Discussion of an immediate security plan with the survivor; arrangement of a mini case conference between the case manager and the coordinator; referral of the survivor to the family protection department as an urgent situation (on the same day); conduction of a follow up with the family protection department to make sure of the decision.
11-15	High risk (emergency)	Organization of a mini-conference between the case manager and the coordinator; immediate referral of the case to the family protection management as an emergency that requires immediate intervention; intensive follow-up by the case management.

Analysis of factors / protection skills surrounding the survival

…….

…….

Case manager and coordinator's necessary recommendations for the identification of the need for medical and legal referrals:

……

……

Referral Date:

Case Manager signature:

Case Management plan It is used by the case manager based on the need assessment results					
Case name: **Case manager name:** **Start date:**					
Services	**Goal**	**Plan**	**Responsibility**	**Time to implement the plan**	**Verification indicators**
Psychological					
Legal					
Protection					
Social					
Health					
Education					
UNHCR					

Communication and Guiding Principles Checklist
Self –Evaluation Tool

Used by the case manager

This is an example of a self-evaluation or monitoring tool for assessing good practices in working with child and women.

PURPOSE

This assessment outlines the basic communication skills that the case managers should demonstrate, and the guidelines to which they should adhere. This should be used by case managers, their trainers, and supervisors to assess their skills in dealing with GBV and CP cases.

RATING

- **Met: If the individual is able to use the questions/statements correctly and fully, he/she will receive a mark of 'met'.**
- **Partially Met: If the individual is able to use at least 50% of the questions/statements, he/she will receive a mark of 'partially met'.**
- **Unmet: If the individual is unable to use the question/statements correctly, he/she will receive a mark of 'unmet'**

Communication & Engagement Skills	Criteria	Met (2 pts)	Partially Met (1 pt)	Not met (0 pt)
Healing statements a GBV survivor should hear throughout his/her care.	• I believe you. • This is not your fault. • I am very glad you told me. • I am sorry this happened to you. • You are very brave for telling me, and we will try to help you. • Other culturally-appropriate healing statements			
Appropriate management of the	The staff welcome the beneficiaries warmly			

intake and assessment session with a GBV survivor.	**The staff introduce themselves and their role** **The survivors receive a clear explanation of their rights and encouragement**			
Use of body language (i.e. position of the body) to help a GBV survivor feel safe and comfortable.	**Use an open body language, including:** **• Use appropriate eye contact.** **• Friendly expression on face.** **• Soft, gentle voice.** **Other culturally-appropriate actions**			
Identifying feelings	**• It sounds like you are feeling....** **• How are you feeling about that?** **• Am I right in saying that you feel….?**			
Validating feelings	**• Acknowledge feelings: You have the right to feel…** **• That makes sense** **• Let the child survivors know it is okay to feel the way they do.** **• Let the survivor know s/he is heard**			
Things to do when the survivor becomes agitated	**• Stay calm.** **• Do not tell them to calm down.** **• Remind them that you are there to help them.** **• Do not assert control or make requests.** **• Offer them a cup of tea or water.** **• Keep your tone of voice calm and soft**			
Concrete acts	**• Understand what the survivor is saying.** **• Focus on specifics to clarify things.** **• Do not give advice, but ask questions that help the survivors clarify for themselves which are the options to consider to make a decision about what they want to do**			
Description of how the caregiver's attitudes and beliefs about VAC can affect communication with	**• They are more committed to caring for the child.** **• They provide accurate and non-judgmental information and counseling.** **•**			

children.				
Guiding Principles for Working with GBV Survivors	**Criteria**	**Met(2 pts)**	**Partially Met (1 pt.)**	**Not met (0 pt.)**
Listening and establishing support	**• Ability to create a safe environment in which the GBV survivor can begin to heal.** **• Good active listening.** **• Warm and welcoming.**			
Ensure safety	**• Primary consideration is given to safety.** **• A safety plan is developed with the beneficiary.** **• Ability to take appropriate measures to ensure the survivor's safety.** **• Ability to explain and maintain confidentiality.**			
Provide emotional support	**• Ability to demonstrate a caring attitude.** **• Ability to maintain a non-judgmental attitude.** **• Ability to handle the situation when the beneficiary is agitated.**			
Provide information	**• Ability to explain case management services and other services clearly and adequately.** **• Ability to highlight any implications or risks associated with the service.** **• Ability to provide information objectively without expressing one's own views and opinions.**			
Respect the wishes, choices, rights, and dignity of the GBV survivor	**• Provide options and not advices.** **• Engage the survivor in the case management process.**			
Obtain informed consent / assent	**• Provide adequate information about the services.** **• Explain the limits to confidentiality.** **• Explain any mandatory reporting rules.** **• Highlight implications and risks of any**			

	service.			
Ensure confidentiality	**• Ability to collect and use information in a confidential manner.** **• Ability to file collected information securely.** **• Share information only on a need-to-know basis**			
Ensure non-discrimination in all interactions with the GBV survivor (e.g. PWDs, LGBTI….) and in all service provisions	**• Treat the GBV survivor in a dignified manner, irrespective of his/her sex, background, race or ethnicity.** **• Treat the GBV survivor in a dignified manner, irrespective of the circumstances of the incident(s).**			
Ensure the best interest of the child	**• Ability to ensure the child's physical and emotional safety throughout care and treatment.** **• Ability to evaluate the positive and negative consequences of all actions involving the child and his/her caregiver (as appropriate).**			
Involve the child in the decision-making process	**Ability to ensure that the child's participation in the decision-making process is appropriate to his/her age and level of maturity.**			
Strengthen the child's resilience	**Ability to identify and build upon the child's and family's natural strengths as part of the recovery and healing process.**			
Total Score				
Evaluating Communication Skills and Guiding Principles Competency **19-38 points: MET: Scores in this range indicate that the individual has met the core communication skills and guiding principles requirements and is able to work independently with GBV survivors with ongoing supervision.** **9-18 points: PARTIALLY MET: Scores in this range indicate additional training is needed to build knowledge and skills on**			**Final Evaluation:** **_____MET _____PARTIALLY MET** **_____UNMET**	

communication and guiding principles. A capacity-building plan should also be put into place. This may include one-to-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity-building activities. **0-8 Points: UNMET: Scores in this range indicate that the staff member does not have yet the sufficient knowledge and skills to communicate with survivors and respect the guiding principles throughout her/his work. Additional training and support should be provided and refresher sessions should be carried out on a regular basis. A capacity-building plan should also be put into place. This may include one-to-one mentoring sessions, additional training opportunities, shadowing fellow staff members, among other capacity-building activities.**	
OTHER OBSERVATIONS AND COMMENTS (Record direct observations of the case manager that should be included in the communication and guiding principles assessment).	

Annex 2

Home Visits Policy[22]

This policy is designed to protect the safety of all staff carrying out home visits. When home visits take place, a risk assessment should be completed in advance. This will identify any concerns about potential risks and appropriate measures to be taken. If specific information is available about the families, this should be included in the risk assessment. Home visits shall always conduct with a second staff member. Home visits can only take place when the policies and protocols are fully met. Policy and procedures must be consistently applied.

The visit provides the opportunity to:

- Establish early, positive contact;
- See survivors in their own familiar environment;
- Meet other family members, people and pets who are important to the survivors;
- Understand the problems that survivors might face.

Staff should bring a mobile phone for safety reasons, a map to locate addresses, and a range of toys/puppets and books/color pencil for the children to play with.

Before the visit

- Show respect for parents and survivors as equal partners.
- Be a good listener.
- Make appointments in advance and offer alternative dates/times.
- Ensure that parents know when you will arrive, how long you will stay, what will happen, what kinds of questions you will be asking and what information you will bring.
- Ask them to think about the information they need from you in advance of the meeting.
- Accept the right of a family to refuse a home visit.
- Confirm the parents' actual name and title and record it. Do not presume that both parents have the same surname as the child.
- Do not assume that all parents/adults are literate.
- Make sure you consider diversity of social, cultural, racial, religious, and sexual orientation.
- Familiarize yourself with the route/ location, parking restrictions etc., before you leave
- Leave details of your visiting schedule with another member of staff.

[22] http://www.durringtoninfantjunior.co.uk/Governors/Policies/Home%20Visits%20Policy.pdf

During the visit

- Be aware of other adults who may be in the house.
- Sit close to a door or an exit and if you feel uneasy or worried at any time, make an excuse and leave.
- Staff should avoid commenting on a survivor's house so that they do not feel that any judgment is being made on their home or lifestyle.
- Staff should demonstrate awareness and respect for different cultures.
- They should comply with the appropriate customs such as removing shoes, wearing modest clothing etc.
- Staff should remain aware of time constraints for both them and the family.

Specific Protocols for All Home Visits Risk Assessment:

- Check records to see the information available.
- Talk to other professionals who may already have had contact or involvement with the family.
- Obtain information about the location of the home visit. For example, does the area have a reputation for being unsafe, isolated or poorly lit?
- Discuss with your line manager the strategies to adopt when working with a potentially challenging family.
- Where potential risks are identified, arrange for an alternative meeting environment.

ALWAYS COMPLETE THE RISK ASSESSMENT BEFORE THE VISIT TAKES PLACE:

- Inform a nominated member of the staff when you are leaving for the home visit.
- Leave the details of the home visit schedule with a senior member of the staff. Include a list of visit addresses and times including family name, address, telephone number, purpose of visit, and time due back at base.
- You must inform the nominated person if there is a cancellation or alteration to the schedule.
- Carry with you and show the family some form of identification.
- Demonstrate normal courtesy – wait to be invited into the house.
- If a child answers the door, ask if an adult is present in the house before entering. Do not enter if an adult is not present.
- If the parent appears at all uncomfortable about the visit continuing, the staff should offer to leave and continue the intervention over the phone and give the parent the telephone number of the center.
- Use common sense, trust your instincts and if a situation seems dangerous or threatening leave, saying, for example, that you need to get something from your car.
- All Home Visits must finish by 16.30.
- Contact the nominated person immediately after the visit is finished, informing her/him that you are safe.

Annex 3

Creative Interview Techniques:

Important note:
These specialized techniques cannot be used without prior training

Getting to know the Child.
Any of the following techniques can involve drawing or playing
If you want to encourage the child to play: invite her/him to choose a toy and describe what he/she is doing; follow the child's lead; ask simple questions; let the child reply through actions in the play; make positive comments; encourage the child to talk.
You can give broad instructions to the child, as those below.

1. **About me** – The child draws a picture that describes him/her. This may enable you to learn their age, how they identify themselves, and how they feel.

2. **My home and family** – The child draws where she/he lives / where she/he stays at night. This may enable you to assess the quality of the child's home life (e.g. If they have adequate shelter and accommodation), including the relationships with other children in the house. You could also ask additional questions about the family and their inter-relations and activities. Drawing the network of support that the child relies on, such as family, friends, teachers may help you understand how well-supported the child is and which people may be able to help in the planned intervention.

3. **My usual day –** It may be useful to discuss what a child does every day. Through this, we can find out how often the child eats, whether she/he goes to school, etc. You could start with a picture of a sun rising, a sun high in the sky, and a sun setting. Then you can invite the child to draw and explain her/his activities at each moment of the day.

4. **Emotions**

   How I feel – You can draw smiling, neutral and unhappy faces and encourage the child to point at these when describing her/himself, different people in her/his life, situations and memories to

try to understand how they feel about them and, if needed, to further explore these relationships or situations.

5. **Safety**

Safety Circle - The child draws a circle and puts inside the circle what and who makes him or her feel safe. This can be an excellent way to identify safety concerns the child may have. The caseworker can take this activity a step further and have the child draw the things outside of the circle that scare her/him (the circle being the symbolic boundary of safety). This can provide additional information about the child's perception of risk (what and who) and safety (what and who).

6. **Family Composition** - Genograms are used to map the family composition. In general, it is advisable that the genogram cover three generations: grandparents, parents and children. It can include additional details, such as important
places and events, a specific accident resulting in special needs for a person, etc. Developing a genogram can help guide discussion on the family history and reflect the family members' feelings about what happened. Caseworkers can observe how family members interact while developing the genogram, including how open they are and how well they know each other. Practice this technique with a colleague using your family as an example.

7. **Barriers and Solutions** – Useful if there are many problems to discuss and it is necessary to decide which ones to prioritize.

- Children write or draw their problems on brick-or block-shaped pieces of paper.
- They put the pieces of paper together to symbolize a 'wall' of problems.
- Children can then take one or two 'bricks' from the wall, which represent urgent and important problems.
- They are then encouraged to think about how these problems could be solved or who could help.

8. **Diamond Ranking** –Useful if we are not sure of which problem is the most urgent / important.

- Children write or draw their problems on diamond shaped pieces of paper.
- They make a larger diamond shape with all the smaller diamond-shaped pieces of paper, with the most urgent and important ones at the top and the least important ones at the bottom.
- Working from the top they are then encouraged to think about how these problems could be solved / who could help.

9. **Venn diagram** – Useful to understand overlapping problems.

- Children write or draw their problems on circular pieces of paper.
- They then organize the pieces of paper so that the problems that are more urgent and important are closer to the center of a larger circle and those that are less urgent and important are further away. Where problems are related or overlap, the pieces of paper can overlap.
- They are then encouraged to think about how the most urgent and important problems could be solved / who could help, and to take into consideration the relation between overlapping problems.
- This helps identify problems, strengths, and objectives.

10. **The Three Houses Model**: Draw three houses and label them as: the house of strengths / good things; the house of worries / fears; and the house of hopes and dreams. The houses can represent the child, or the child and his/her family and their environment. Explain that the child can write or draw, in any order, on each of the houses the things in their life related to it, .

    Use the following prompting questions, if necessary, reflecting things they shared during the assessment:

    Risks/Vulnerabilities/Worries: What makes your house vulnerable/sad/insecure? Factors internal to the house include emotions, behaviors, and physical well-being. External factors include factors/practices/people that are perceived as a risk/worry.

- Strengths/Good Things: What makes your house strong/happy/good? This identifies the same kind of factors as the first house but focuses on the positive aspects.
- Hopes and Dreams for the Future: What would you like to be different in your life? What are your goals / aspirations? How would things look if your goals were reached? If you could wake up tomorrow and your dreams had come true, what would you notice? What would be different? Children and families are then asked what needs to happen for them to build the house of their hopes and dreams and who can help them do this. What building material do you have? What other help do they need? The identified ‘building materials/resources/supports' are then used to create a pathway of small, achievable steps towards the case plan goal.

Annex 4: Disability Safe Space

Disability Safe Space: A Space that creates the conditions to ensure that persons with disabilities are not subjected to violence, abuse or neglect, and provides the various facilities they need to access services without any risk, promoting an environment that fosters their autonomy and their inclusion into society.

How to guarantee Minimum Standards for Disability Safe Spaces[23] [24] [25]

1. Ensure that the Disability Safe Spaces (DSS) are accessible for men, women, boys and girls with special physical and intellectual needs. This could include practical solutions, such as creating ramps or grabrails if needed.

2. The safe space should be located in an area that is accessible to people with disabilities and ensures safety and privacy. The decision on where to locate the safe space should be made by the beneficiaries. If that is not feasible, they should at least be consulted. Accessibility should also consider timings and days that work best for them. If possible, transportation costs to and from the space should be covered.

3. Each DSS should have hand-washing facilities (including soap); clean water, including drinking water, should be available..

4. The DSS should have toilet/latrine facilities, located inside the center and easily accessible. There should be either separate facilities for men and women or a mechanism to ensure that they do not use the toilets at the same time. The age factor should also be taken into account when designing latrines/toilets and deciding where to situate them. Toilets should be situated and designed to respond to the PWDs need for privacy, dignity, safety and take into account any kind of disability. In addition, they should be easily accessible from the center's recreational facilities.

5. Staff members should use toilet and bathroom facilities separate from those used by beneficiaries. If that is not possible, staff members may use the same facilities only when beneficiaries are not using them.

6. Where possible, each DSS should ensure that toilet facilities can be locked from the inside and that only staff members are able to open the doors of bathrooms, showers and toilets from the outside in case of emergency.

[23] file:///C:/Users/gts/Desktop/Child_Friendly_Spaces_Guidelines_for_Field_Testing.pdf

[24] cpwg.net/wp-content/.../Minimum-Standards-CFS-FINAL-Sudan-October-2011.doc

[25] https://reliefweb.int/sites/reliefweb.int/files/resources/cfs_minimum_standard_-_cxb_cpss_2018.pdf

This ensures that the PWD's right to privacy is respected. It also reduces the risk of abuse or inappropriate behavior.

7. Each DSS should ensure that the bathroom facilities are regularly cleaned (at least daily) and disinfected. Beneficiaries should be encouraged to take responsibility for keeping the facilities clean.

8. Each DSS should have recreational facilities and host on-site activities tailored to the different needs of the PWDs. Such activities contribute to the development of the PWDs, from a physical, social, and intellectual point of view.

PWDS should have access to all activities, according to their preferences.

9. The indoor playing areas, where possible, should have natural lighting and proper ventilation. The indoor play areas should be designed to promote all areas of Children WDs' development (social, physical, intellectual, creative and emotional) and should, subject to availability, include areas equipped for dramatic play, interactive play and education, art activities, motor skills activities, as well as a quiet area. Equipment and playing materials should be culturally sensitive and age-appropriate. The indoor playing areas should be organized so that children can choose and access playing materials with minimal assistance (e.g. low shelves, open boxes, etc.).

10. The DSS should have an outdoor playing area as large as the space permits, allowing sufficient space for team sports and other recreational activities.

11. The DSS and surrounding playing area should be demarcated and fenced off on all sides. It should have specific entrance(s) through which people can enter and exit, to facilitate monitoring the movement of beneficiaries, staff and others in and out of the center.

12. The DSS should ensure that the number and variety of the indoor and outdoor playing areas and equipment are adequate to the number and age of the PWDs, as well as that the equipment is safe and in good conditions. Whenever possible, recreation/art materials should be chosen in consultation with the beneficiaries.

13. The equipment in the outdoor playing areas should be positioned at a height suitable for the age and height of the children WDs using it. Separate outdoor playing areas, with age appropriate equipment, should be provided for infants and toddlers. The equipment in the outdoor playing areas should be cleaned, maintained and checked prior to use by the children, to ensure its safety.

14. Shaded areas (e.g. trees; buildings; awnings; etc.) should be available in and around the outdoor playing areas and, if possible, the outdoor play areas should include a variety of ground surfaces to encourage a range of activities. Cushioning or sand should be placed under and around climbing structures/slides/swings to avoid injuries.

15. Recreational spaces should be used as an opportunity for PWDs to present and express their work and creativity. The PWD's artworks, drawings, sculptures and other crafts should be prominently displayed in the DSS.

The equipment in the outdoor playing areas should be appropriate to the beneficiaries' physical attributes and level of development in order to meet their needs in all areas of development. The maintenance of the equipment therein is key to ensuring the safety of the beneficiaries: the equipment and playing materials available to PWDs are maintained properly, to allow the PWDs to play safely and fully enjoy the playing areas.

16. Each DSS should be endowed with a space for the treatment of any injuries or minor illnesses that may occur to the children while under the care of the center's staff. This space shall be adapted to the children's different needs.

17. If no clinic is available in the vicinity, a staff member with first aid training should be present at DSS at all times and first aid kits shall be available.

18. The DSS should assist in promoting the beneficiaries' health and life skills. This action should be carried out by specialist medical staff and includes, but is not limited to, the promotion of immunization and screening, nutrition and diet, exercise and rest, personal hygiene, child rights and, where appropriate and culturally acceptable, the creation of awareness about sexual health and the effects of alcohol, smoking and other substances.

19. When dealing with sick or injured beneficiaries, staff members should always wear gloves or use plastic bags to protect their hands.

20. There should be facilities for proper waste disposal. This rubbish should be burned or buried in a location outside the DSS.

21. Any materials like wash cloths or towels used to wipe faces or clean messes should be kept away from beneficiaries and washed and soaked in a container to ensure they are completely sanitized before re-use.

22. DSS catering to Person with disabilities should ensure the provision of assistive devices and equipment, personal assistance and interpreter services, according to the needs of persons with disabilities. They should take the special requirements of PWDs into account with regard to the design, durability and age-appropriateness of assistive devices and equipment.

23. The DSS staff should undertake efforts to promote the inclusion and participation of PWDs and assist them and their caregivers to access education, health care services, rehabilitation services and recreational opportunities in a manner conducive to the PWDs fullest possible social integration and development.

24. The DSS should ensure that PWDs have a full experience at the DSS, in conditions that ensure dignity, promote self-reliance, and facilitate their active participation in the community.

25. A policy on alternative forms of discipline, including a ban on the use of corporal or physical punishment, should be developed and implemented.

26. There should be a record of the beneficiaries (one enrolment list and one attendance list) at the DSS, i.e. where they came from, date first used services and DSS and the frequency of use, why they came to the DSS, records of primary caregivers-parent/sand special needs. Every beneficiaries' enrolment record should be comprehensively updated at least once every month, and when any changes to their information occur; records should be kept as long as the client is using the services at the center. Each DSS/organization should identify a specific individual responsible to monitor the record keeping process.

27. Different times or spaces should be allocated for PWDs in different age-groups in order to protect beneficiaries and promote appropriate peer interaction. Separate age-appropriate activities should be organized and implemented for the different age-groups.

28. Timing of DSS activities for school-age children should not conflict with school attendance.

29. Timing of DSS activities for women and men should not conflict with their tasks/jobs.

30. clients themselves should, as much as possible and age, be involved and participate in the selection, development, planning and implementation of activities and events at the DSS.

31. The DSS shall ensure parental and community consultation and participation in the development of the activities conducted at the DSS. The DSS should also serve as a mechanism for awareness raising and sensitization within the community on Gender based Violence issues. The DSS should hold at least one activity per month, be it a consultation, an awareness raising session, a discussion group meeting, or other activities to promote community and parental involvement.

32. Efforts should be made to ensure that culturally and age-appropriate activities are available for girls, boys, women and men in order to ensure equal gender participation in DSS.

33. Each DSS should hold a minimum number of regular activities, which can include psychosocial support/wellbeing, recreation, games, arts and crafts, non-formal education, life-skills, etc., with a regularly scheduled and properly communicated plan of implementation (possibly displayed within the DSS).

34. The beneficiaries shall be free to choose the activities DSS in which they want to participate and under no conditions they should be forced to participate in any activity against their will.

35. An attempt should be made to achieve a gender balance (i.e. an equal number of men and women) among the service providers.

Annex 5

Parenting discipline for children with disability

Be Consistent

The benefits of discipline are the same whether kids have special needs or not. In fact, kids who have trouble learning respond very well to discipline and structure. However, for this to work, parents have to make discipline a priority and be consistent.

Correcting kids is about establishing standards — whether it is about setting a morning routine or dinnertime manners — and then teaching them how to meet those expectations. All kids, regardless of their needs and abilities, need this consistency. When they can predict what will happen next in their day, they feel confident and safe.

Yes, they will test these boundaries — all kids do. But it is up to you to affirm that these standards are important and let your child know that you believe he or she can meet them.

Learn About Your Child's Condition

To understand your child's behavior, you have to understand the things that affect it — including his or her condition. Therefore, no matter what challenge your child faces, try to learn as much about the unique medical, behavioral, and psychological factors that affect his or her development.

Read about the condition and ask the doctor about anything you do not understand, to help determine if your child's challenging behavior is typical or related to his or her individual challenges.

Defining Expectations

Establishing rules and discipline are a challenge for any parent. Therefore, you shall keep your behavior plan simple and work on one challenge at a time. As your child meets one behavioral goal, he or she can strive for the next one.

Here are some pointers.

Use Rewards and Consequences

Adopt a system that includes **rewards** (positive reinforcement) for good behavior and **natural consequences** for bad behavior. Natural consequences are punishments that are directly related to the behavior. For example, if your child is throwing food, you would take away the plate.

However, as not every child responds to natural consequences, you might have to match the consequence to your child's values. For instance, a child with autism who likes to be alone might consider a traditional "time out" rewarding — instead, you may take away a favorite toy or video game for a period of time.

After correcting your child for doing something wrong, offer a **substitute behavior**. For example, if your child is talking too loudly or hitting you to get your attention, work on replacing that with an appropriate behavior such as saying or signaling "help me" or getting your attention in appropriate ways, such as tapping your shoulder. **Active ignoring** is a good consequence for misbehavior meant to get your attention. This means not rewarding bad behavior with your attention (even if it is negative attention, like scolding or yelling).

Use Clear and Simple Messages

Communicate your expectations to your child in a simple way. For kids with special needs, this may require more than just telling them. You may need to use pictures, role playing, or gestures to be sure your child knows what he or she is working toward.

Keep verbal and visual language simple, clear, and consistent. Explain as simply as possible what behaviors you want to see. Consistency is key so make sure that grandparents, babysitters, siblings, and teachers are all on board with your messages.

Offer Praise

Encourage accomplishment by reminding your child about what he or she can earn for meeting the goals you have set, whether it is getting stickers, screen time, or listening to a favorite song. And be sure to praise and reward your child for his/her effort as well as success. In this sense, a child who refuses to poop in the toilet may be rewarded for using a potty near the toilet.

Another strategy might be to practice "time-in" — when you catch your child doing something right, praise him or her for it. In certain cases, time-in can be more effective than punishment, because kids naturally want to please their parents. By getting credit for doing something right, they will likely want to do it again

Establish a Routine

Children with certain conditions, like autism and ADHD (attention deficit hyperactivity disorder), respond particularly well to discipline that is based on knowing exactly what will happen next. You can therefore try to stick to the same routine every day. For example: If your child tends to melt down in the afternoon after

school, set a schedule for free time. Maybe he or she needs to have a snack first and then do his/her homework before playtime.

Charts can be helpful. If your child is non-verbal or pre-verbal, draw pictures or use stickers to indicate what comes next. Set a schedule that is realistic and encourage input from your child where appropriate.

Believe in Your Child

If, after taking his first steps, your little one kept falling down, would you get him some crutches or a wheelchair? No. So do not do the same with a child with special needs. Maybe your child cannot put on his or her shoes the first time, or the tenth time, but keeps trying. Encourage that!

When you believe your child can do something, you empower him or her to reach that goal. The same is true for behavior. For example, if your child is too aggressive when playing with other kids, do not stop the play altogether. Instead, work with your child to limit the physicality of the play. You may want to plan non-physical activities during play dates, like arts and crafts projects. Use discipline where necessary in the form of time-outs, enforced turn-taking, and rules like "no touching" — and provide rewards when your wishes are met.

Have Confidence in Your Abilities

Discipline is an exhausting undertaking. There will be good days when you're amazed by your child's progress, bad days when it seems like all your hard work was forgotten, and plateaus where it seems like further progress is impossible. But remember this: behavior management is a challenge for all parents, even those of kids who are typically developing. So, do not give up!

Advice for parents of disabled children [26]

- If we expect that our children will attain goals that are clearly not attainable, we will set ourselves up for disappointment and set them up for failure.
- Take breaks in your home when you can. Make yourself a bubble bath, go for an evening walk, or read a book unrelated to your child's condition. You need to take care of yourself in order to better take care of your child.
- The old saying "laughter is the best medicine" exists for a reason. You can feel the weight being temporarily lifted as the laughter releases the tension pent up in your body.

[26] https://www.thechaosandtheclutter.com/archives/advice-parents-special-needs-children

- Take the time to work on your relationship. This may be easier said than done, but the alternatives would bring about very serious consequences.

- Build a strong support system based on family and friends and build a sense of community by involving yourself (to the extent that your circumstances allow) in the work of a community center.

- Celebrate the small victories. Keep a log of what happens so that when there are improvements with your child, you can look back and see how far they have come.

Annex 6: Tips for quality attention

Open – Not Closed

Mind your body language: uncross your arms, look at the other person, and show that you are interested in communicating.

Encourage – Do not Push

Give people time to think. By making small comments like “tell me more about that,” “what was that like for you,” or by just nodding with your head, you can help people feel safe and open.

Support – Do not Judge

Simply reminding people that we are there to support them, without judging, can help them feel accepted, thus reducing their feelings of stigma and shame.

Listen More, Speak Less

Giving people the opportunity to speak can make them feel heard and important.

It is important to use the proper words, when discussing people with disabilities. When talking about a person with disability, it is best and most polite to put his/her personality before his/her own condition. Example: rather than "mentally disturbed", it is better to say, "Someone with a mental disability". Rather than "paralyzed", "someone who uses a wheelchair".

Communicate directly

Communicate, talk and look to the person with disabilities and do not talk to his / her facilities or make the conversation through an intermediary.

Ask before you offer help

When a person with a disability has difficulties in doing something you will often feel like trying help him/her right away. However, as you do not know the needs of this particular person, you should always ask him/her before you try to help.

Be respectful in your talk and your actions

You should always talk and behave respectfully towards the beneficiaries of the Center's services, including women and children with disabilities.

Speak naturally

People often feel that they should speak loudly and slowly, especially if they are talking to someone who is deaf, but this behavior may seem insulting. Speak with your usual voice without any change.

Open / not closed or suggestive questions

Give the space to the beneficiary to tell you his/her story in his/her words. Asking questions in the right way facilitates the evaluation process; do not ask, for example, "Did you feel angry then?" but rather "Tell me what you felt when this happened".

Do not ask for what the person did

The question of "what you did" enhances the sense of guilt.

Do not ask curious questions

Only require the information that will benefit you for evaluation purposes and help you provide a better service.

Be a professional / not a friend

When dealing with survivors of gender-based violence, do not allow the relationship to drift into a friendship, but always maintain a professional distance between you and the beneficiaries.

Maintain the privacy of the survivor.

Annex 7:

Evaluation Tool

Tool for testing the staff attitudes to GBV before recruitment.

This is an example of an evaluation or monitoring tool for testing attitudes to GBV in the staff before the recruitment. The general principles impose ethical and behavioral responsibilities in the provision of services to children and adults, and ensure that all workers are assessed and held accountable for working with survivors of gender-based violence and thus ensure the best possible care.

RATING

- **Positive Attitude: from 26-36**
- **Neutral: from 18-26**
- **Negative Attitude: from 0-18**

In this community and elsewhere, people have different ideas about families and what is acceptable behavior for men and women in the home. I am going to read you a list of statements and I would like for you to tell me whether you agree or disagree with the statement. I would know about general thoughts you have about relationships.

a. A good wife obeys her husband even if she disagrees.	**1. Agree** **2. Disagree** **3. DK**
b. Family problems should only be discussed with people in the family.	**1. Agree** **2. Disagree** **3. DK**
c. It is important for a man to show his wife /partner who is the boss.	**1. Agree** **2. Disagree**

	3. DK
d. A woman should be able to choose her own friends even if her husband disapproves.	**1. Agree** **2. Disagree** **3. DK**
e. It's a wife's obligation to have sex with her husband even if she doesn't feel like it.	**1. Agree** **2. Disagree** **3. DK**
f. If a man mistreats his wife, others outside of the family should intervene.	**1. Agree** **2. Disagree** **3. DK**
g. In your opinion, does a man have a good reason to hit his wife if: **1. she does not complete her household work to his satisfaction** **2. she disobeys him** **3. she refuses to have sexual relations with him** **4. she asks him whether he has other girlfriends** **5. he suspects that she is unfaithful** **6. he finds out that she has been unfaithful**	**YES NO DK** **1 2 3** **1 2 3** **1 2 3** **1 2 3** **1 2 3** **1 2 3**
h. In your opinion, can a married woman refuse to have sex with her husband if: **1. she doesn't want to** **2. he is drunk** **3. she is sick**	**YES NO DK** **1 2 3** **1 2 3**

4. he mistreats her	**1 2 3** **1 2 3**
i. How do you think the refugee situation and the war has affected the frequency of violence between husbands and wives in your community? Based on what you've seen and heard in your community, do you think conflict between husbands and wives has decreased, stayed the same, or increased since the war?	**1. Decreased** **2. Stayed the same** **3. Increased** **4. DK**
j. If a woman was being mistreated by her husband, what do you think are the best ways she might cope with her husband's mistreatment? (circle all mentioned)	**1. Support group for women** **2. Talking it over with friends** **3. Talking it over with family** **4. Assistance from NGO workers** **5. Legal advice/traditional justice** **6. Religious counseling** **7. Mental health counseling** **8. Medical assistance** **9. Trying to forget about the mistreatment** **10. Other** **11. DK**

The Key answer:

		The rate
a. A good wife obeys her husband even if she disagrees.	**1. Agree** **2. Disagree** **3. DK**	**1. 0** **2. 2** **3. 1**
b. Family problems should only be discussed with people in the family.	**1. Agree** **2. Disagree** **3. DK**	**1. 0** **2. 2** **3. 1**
c. It is important for a man to show his wife /partner who is the boss.	**1. Agree** **2. Disagree** **3. DK**	**1. 0** **2. 2** **3. 1**
d. A woman should be able to choose her own friends even if her husband disapproves.	**1. Agree** **2. Disagree** **3. DK**	**1. 2** **2. 0** **3. 1**
e. It's a wife's obligation to have sex with her husband even if she doesn't feel like it.	**1. Agree** **2. Disagree** **3. DK**	**1. 0** **2. 2** **3. 1**
f. If a man mistreats his wife, others outside of the family should intervene.	**1. Agree** **2. Disagree** **3. DK**	**1. 2** **2. 0** **3. 1**
g. In your opinion, does a man have a good reason to hit his wife if:	**YES NO DK**	**G1:** **1. 0** **2. 2**

1. she does not complete her household work to his satisfaction 2. she disobeys him 3. she refuses to have sexual relations with him 4. she asks him whether he has other girlfriends 5. he suspects that she is unfaithful 6. he finds out that she has been unfaithful	1 2 3 1 2 3 1 2 3 1 2 3 1 2 3 1 2 3	3. 1 G2: 1. 0 2. 2 3. 1 G3: 1. 0 2. 2 3. 1 G4: 1. 0 2. 2 3. 1 G5: 1. 0 2. 2 3. 1 G6: 1. 0 2. 2 3. 1
h. In your opinion, can a married woman refuse to have sex with her husband if: 1. she doesn't want to 2. he is drunk 3. she is sick 4. he mistreats her	YES NO DK 1 2 3 1 2 3 1 2 3 1 2 3	H1: 1. 2 2. 0 3. 1 H2: 1. 2 2. 0 3. 1 H3: 1. 2 2. 0 3. 1 H4: 1. 2 2. 0 3. 1
i. How do you think the refugee situation and the war has affected the frequency of	1. Decreased	1. 0 2. 1

violence between husbands and wives in your community? Based on what you've seen and heard in your community, do you think conflict between husbands and wives has decreased, stayed the same, or increased since the war?	2. Stayed the same 3. Increased 4. DK	3. 2 4. 1
j. If a woman was being mistreated by her husband, what do you think are the best ways she might cope with her husband's mistreatment? (circle all mentioned)	1. Support group for women 2. Talking it over with friends 3. Talking it over with family 4. Assistance from NGO workers 5. Legal advice/traditional justice 6. Religious counseling 7. Mental health counseling 8. Medical assistance 9. Trying to forget about the mistreatment 10. DK	1. 2 2. 1 3. 1 4. 2 5. 2 6. 2 7. 2 8. 2 9. 0 10.0